

**PHI Authorization Family/Friend
Glen Meade Obstetrics & Gynecology, P.A.**

In accordance with our "Notice of Privacy Practices", we may disclose your personal health information to a family member, relative, friend or other person identified by you. Please list below the names of ALL persons you would permit to have such access to your personal health information.

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship

Please Note: In calling our physicians or office for medical information, we prefer to speak with the patient directly unless it is an emergent situation. **Any person calling for you should be able to identify your date of birth, physician name, problem or procedure performed, and preferably your chart number.** This enables us to further protect your right to privacy.

This authorization will continue until revoked or terminated by the patient in written revocation received by Glen Meade Center for Women's Health.

Patient Name (Please Print)

Patient Signature

Date