



Patient Authorization Form

I hereby authorize Boyd Obstetrics & Gynecology, S.C., to release information regarding my protected health information to the following persons and/or agency listed below.

I also understand if there is a change in the information provided below, I must notify Boyd Obstetrics & Gynecology, S.C., in writing.

Patient Name: _____

Signature: _____

Relationship to Patient (if signed by personal representative of Patient):

_____ Date: _____

Note: You do not have to list physician offices, insurance companies or pharmacies. Please list all individuals you wish to be able to contact our office and for us to contact in regards to your Health Information.

Name/Agency

Relationship

