



Authorization to Disclose Protected Health Information to Family Members and Others

“I authorize disclosure of my protected health information for purposes of communicating results, findings and care decisions to my family members and others as indicated below.”

“I acknowledge that no information regarding my healthcare can be communicated without my permission unless I become incapacitated. If I become incapacitated healthcare providers will communicate to individuals assigned in advanced directives previously designated by me. If no advanced directive has been designated I acknowledge that healthcare providers will communicate to my nearest next of kin.”

Name	Relationship	phone#	Password (unique identifier)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date and Time

\*\*Please select a unique identifier or password that you will need to give to the individual(s) listed above. Los Olivos Women’s Medical Group, Inc can identify those individual(s) particularly when they phone us with this unique identifier or password before we give them information about you. Thank you.

I do not want to designate anyone to receive my protected health information. If this is a change and there are individuals listed above, please cross them out. Check the box above and complete the signature information below.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Witness Signature