OB GYN Associates
2769 Heartland Drive, Suite 201
Coralville, IA 52241

Account #_____

Request for Confidential Communication of Protected Health Information

Patient Information:

Legal Name:_____ Preferred Name:_____ DOB:_____

Mailing Address:_____

City/State/Zip:_____

Race	**Ethnicity**
□ White □ Asian □ Other	□ Hispanic/Latino
□ Black/African American	□ Not Hispanic/Latino
□ American Indian/Alaskan Native	□ Declined
□ Native Hawaiian/Pacific Islander	
□ Declined	

SSN:_____ Primary Number

Cell Phone: _____ □

Home Phone: _____ □

Work Phone: _____ □

Email: _____

Financially Responsible/Statement Recipient: (if minor, must list parent/guardian)

Name:_____ Relationship to Patient:_____

Mailing Address: _____

City/State/Zip:_____

If we are contacted by someone that you know personally (example: parent, spouse, friend), may we release information to them? (Please select only one option.) If minor, must include parent/guardian for Financial information

□ No, I prefer no information is released.
□ Yes, information can be given to the contact below:

Name: _____

Relationship: _____ Phone: _____

Information to be released to alternate contact (please check any that apply):

□ Medical information (including but not limited to information about STDS, pregnancy, and birth control)
□ Appointment dates/times
□ Financial information about my account
□ Other (please specify):_____

Emergency Contact (Please select only one option):

□ Please use the contact person I provided above as my emergency contact.
□ The following person may be contacted in case of an emergency:

Name: _____

Relationship to Patient: _____ Phone: _____

I understand this authorization will remain in effect until I revoke or change it. I may do this at any time by contacting OB GYN Associates in writing.

Patient Signature: _____ Date: _____

Office use only:

_____Employee Initials
□ PBM Consent □ Photo □ Changes updated in GW □ Portal Invite □ Copay Flag