



RIVERWALK OB/GYN, P.L.L.C.
www.riverwalk-obgyn.com

Date: _____

Patient Authorization to release information to Family or Non-Family Member

I, _____ authorized Riverwalk OB-GYN to release to
(PRINT PATIENT NAME)

_____ any information regarding my physician
(NAME OF PERSON & RELATIONSHIP TO PATIENT)

appointment dates and times, status of my patient account (balances) or information in my medical records. I understand if at any time I decided to change this authorization I must submit it in writing within (30) days to the Administrator, Riverwalk OB-GYN. I understand that Riverwalk OB-GYN will not be held liable if information is given to the person(s) I designate as you requested.

Also, to ensure the highest confidentiality when receiving inquiries, the person(s) who you give access to must know these THREE THINGS when asked by a staff member: your birth date, SSN, and your patient account number, or they will be denied access to your information, there are no exceptions to this rule. Please ensure that you give the person(s) this information about you to prevent any delay.

This authorization will remain in-place unless I notify Riverwalk OB-GYN in writing to replace, update, or delete this document. I also give the following members authorizations:

(NAME & RELATIONSHIP)

(NAME & RELATIONSHIP)

PATIENT SIGNATURE

PATIENT ACCOUNT NUMBER IS: _____

STAFF MEMBER (PRINT NAME)

STAFF MEMBER SIGNATURE

cc: copy given to patient