John A. Haugen Associates, P.A.
Obstetrics & Gynecology

HIPAA Authorization for Communication of Information

John A. Haugen Associates, P.A. recognizes that patients have a right to privacy. Consequently, our practice and its physicians and staff will not disclose personal healthcare information unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by federal or state law.

☐ Yes, to facilitate the communication of test results and other information I authorize ***John A. Haugen Associates, P.A.*** to leave confidential information and/or test results on my voicemail if unable to reach me directly.

o Phone Number _____

☐ I do NOT authorize ***John A. Haugen Associates, P.A.*** to leave confidential test results and/or messages on my voicemail.

I am aware that this will be in effect until I notify in writing that this no longer is applicable.

_____ _____
Patient Signature Date

_____ _____
Print Name Date of Birth

OPTIONAL – if you would like your spouse/significant other/guardian/or family member to have access to your personal health information

MINORS (patients under the age of 18): Please be aware that parent/guardian are unable to receive information on their minor child without the below consent signed.

I give ***John A. Haugen Associates, P.A.*** permission to release any of my personal health information

to: _____.

I am aware that this will be in effect until I notify in writing that this no longer is applicable.

_____ _____
Patient Signature Date

_____ _____
Patient Name Date of Birth

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