Blue Ridge OB-GYN, Inc.
541 Sunset Lane, Suite 301
Culpeper, VA 22701
Telephone 540-825-4557 and Fax 540-825-4566

# Authorization to Use or Disclose Protected Health Information

Patient Name: ____________________ Date of Birth __________________________

Daytime Telephone Number ______________

I, ___________________________, understand Blue Ridge OB-GYN, Inc. is authorized by me to use or disclose my Protected Health Information (PHI) for a purpose other than treatment, payment, or health care operations, as designated below. I have read this authorization and understand the designated information will be disclosed only to the recipient(s) outlined below. I specifically authorize any current employee or owner of Blue Ridge OB-GYN, Inc. to disclose the information as outlined. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing at a later date.

My medical information may be discussed with the following person(s)

| Name | Relationship | Phone |
|---|---|---|
| ________________________ | _______________________ | ________________ |
| ________________________ | _______________________ | ________________ |
| ________________________ | _______________________ | ________________ |
| ________________________ | _______________________ | ________________ |
| ________________________ | _______________________ | ________________ |

Signature ___________________________________________

Date _______________________________________________