Privacy Practices Acknowledgement
Designated Party Release Form



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Evans, Ga. 30809

You may give **OBGYN Partners of Augusta, P.C.** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

Patient's Name: _____ Date of Birth:_____

At my request, I authorize OBGYN Partners of Augusta, P.C. to disclose my protected health information to:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

At my request, I also authorize OBGYN Partners of Augusta, P.C. to communicate my protected health information to me via the following methods:

☐Leave detailed message on my **home answering machine**. Phone number: (___) _____

☐Leave detailed message on my **voice mail at work**. Phone number: (___) _____

☐Leave detailed message on my **cell phone voice mail**. Phone number: (___) _____

☐Fax detailed medical information. FAX number: (___) _____

☐E-mail detailed medical information. Email address_____

☐I agree to receive text messages to this mobile phone number (___) _____reminding me about my upcoming appointments, ability to electronically check-in and MyChart updates. I understand that SMS reminders are optional and that message & data rates may apply.

I understand that I may cancel this authorization at any time. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action OBGYN Partners of Augusta, P.C. took in reliance on this authorization before receipt of written notice of cancellation.

I understand that electronic media, and delivery methods such as email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of OBGYN Partners of Augusta, P.C. I agree to assume such risks personally, and to hold OBGYN Partners of Augusta, P.C. harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing OBGYN Partners of Augusta, P.C. to transmit or deliver such information electronically.

_____ Initial I have been offered a copy of Notice of Privacy Practices for the above office; I also understand that this information is available online at www.obgynaugusta.com

Patient's Signature: : _____ Date:_____

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Receiving Employee _____ Date received _____

☐ Copy given to patient