AUSTIN AREA
OB-GYN & FERTILITY

Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____

Birth Date: _____

I HEREBY AUTHORIZE AUSTIN AREA OBGYN TO SHARE:

- ☐ ALL of my medical/dental information- **including information about:**
  [ ] STD testing and treatment* [ ] HIV/AIDS testing and treatment*
  [ ] Mental health diagnoses and treatment* [ ] Pregnancy test and prenatal care*
  [ ] Drug and alcohol use history and treatment* [ ] Birth control/family planning*
- ☐ My lab results ***(Note: selecting this does NOT mean we will share results of STD or HIV/AIDS tests)***
- ☐ The appointment times, dates and reasons for visits
- ☐ The medications I am taking
- ☐ The following information (specify): _____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____ Ph #: _____

Full Name: _____ Relationship: _____ Ph #: _____

Full Name: _____ Relationship: _____ Ph #: _____

I understand that I may cancel this consent at any time (by notifying Austin Area OBGYN), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires: (on date) _____ OR [ ] when I cancel in writing
If no expiration date or event is specified, this authorization will expire one year after the date it is signed.

Signature: _____ Date: _____
Relationship to minor patient (if parent or legal guardian):* _____

Witness: _____ Date: _____
**A minor patient's signature is required for us to share information about care for: (1) conditions relating to the minor's sexuality including, but not limited to: family planning and sexually transmitted diseases (age 14 and above);(2)alcoholism and/or drug abuse (age 13 and above); and (3) mental health conditions (age 13 and above).*