Moreland OB-GYN Associates, S.C.

AUTHORIZATION FOR CONFIDENTIAL COMMUNICATION

I authorize Moreland OB/GYN to release medical information to the following person(s) on my behalf.
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must provide the revocation in writing to Moreland OB/GYN. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- ☐ I am **a minor** and understand that certain aspects of my medical records are accessible to my parents.
  I **wish** to keep the following information **confidential -**
  - ☐ Pregnancy
  - ☐ Sexual Activity
  - ☐ Birth control
  - ☐ Smoking
  - ☐ Drug use

- ☐ I am **NOT a minor** and am authorizing release of the following information **ONLY**

  _____

Name of person(s) receiving information _____

_____

Relationship to patient

- ☐ Mother
- ☐ Father
- ☐ Other _____

This authorization will be in effect for one year unless revoked

Signature _____Date_____

Updated 4/2014