

RELEASE OF MEDICAL INFORMATION BY ALTERNATIVE MEANS

Patient Name: _____ SSN: _____

I authorize Mid-South Perinatal Associates, PC to release the following medical information as listed below:

Please circle yes or no.

Return Appointments: yes no Ultrasound Results: yes no

Out-Patient Testing: yes no Return Calls: yes no

Lab Results: yes no Amino Results: yes no

Signature: _____ Date: _____

Mid-South Perinatal can release the above information to the following people:

Name & Relationship: _____

Name & Relationship: _____

Name & Relationship: _____

Mid-South Perinatal can release the above information by the following means:

Please enter phone number or address.

Answering Machine: _____ Mobile Phone: _____

Email address: _____ Voice Mail: _____

Fax: _____

Signature: _____ Date: _____

****Please sign below to cancel the Release of Medical Information by Alternative Means.****

Signature: _____ Date: _____

(Signature of Responsible Party if Patient is a Minor) Date: _____