

## Consent for Release of Confidential Information

I, \_\_\_\_\_, hereby give my consent to Olathe Obstetrics and Gynecology, P.A./or physician or physician's staff to give or leave test results as follows:

Check any applicable section(s)

\_\_\_\_\_ Do not leave test results with anyone other than me.

\_\_\_\_\_ You may leave test results with myself or the following person(s):

\_\_\_\_\_ (Name)

\_\_\_\_\_ (Name)

\_\_\_\_\_ You may leave test results on the answering machine or voice mail at the number listed below:

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician's office. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information.

Signature of patient/guardian: \_\_\_\_\_

Signature of witness: \_\_\_\_\_

Date: \_\_\_\_\_