Northpointe
Obstetrics & Gynecology, P.C.
Competent, compassionate health care for women.

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I give Northpointe Ob/Gyn authorization to release information regarding my health to the following people: (i.e., spouse, siblings, parents, etc.)
Please note that anyone not listed on this form, including immediate family members and/or relatives, **will not** have access to any information in your medical file.

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Signature: _____ Date: _____

If our office cannot reach you personally, may we leave protected health information (i.e. Test results, appointment dates returned messages, etc.) by the following methods:

Email Address: _____

With a family member Yes☐ No☐

Home answering machine: Yes☐ No☐

Cellular phone voice mail: Yes☐ No☐ Cell phone ( ) _____

By mail to home address: Yes☐ No☐

Print Name: _____

Patient Signature: _____ Date: _____