Altoona Ob/Gyn Associates, Inc.
HIPAA & Emergency Contact Information

Patient authorization to remove HIPAA and/or Emergency Contact

By signing this form, I authorize Altoona Ob/Gyn Associates, Inc., to remove the following access from my Pro-tected Health Information (PHI):

1) Name _____ _____ _____
Please Print Name DOB Relationship

Phone number (Home) _____ (Cell) _____ (Work) _____

2) Name _____ _____ _____
Please Print Name DOB Relationship

Phone number (Home) _____ (Cell) _____ (Work) _____

3) Name _____ _____ _____
Please Print Name DOB Relationship

Phone number (Home) _____ (Cell) _____ (Work) _____

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Emergency Contact Person

(If contact is same as above, please indicate by writing "same as above")

1) Name _____ _____ _____
Please Print Name DOB Relationship

Phone number (Home) _____ (Cell) _____ (Work) _____

2) Name _____ _____ _____
Please Print Name DOB Relationship

Phone number (Home) _____ (Cell) _____ (Work) _____

Patient name (print) _____ DOB _____

Patient signature _____ Today's date _____