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 from access to my Protected Heath 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)_____

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 _____