Gynecologic Oncology and Pelvic Surgery Associates
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RELEASE OF PATIENT INFORMATION CONSENT FORM

PATIENTS NAME: _____

PATIENTS DOB: _____ SOCIAL SECURITY: _____

RELEASE INFORMATION TO VOICE MAIL

In the event we are unable to speak to you directly may we leave a message on your voice mail regarding test results or prescription information? **If yes** please provide us with the phone number(s). **If no** please do not put in any phone number(s).
1._____2._____3._____

RELEASE INFORMATION TO FAMILY/FRIENDS

You have my permission to contact the following individual(s) listed below for whom I designate to be informed of my medical care.

1. _____ At _____ Relationship: _____
2. _____ At _____ Relationship: _____
3. _____ At _____ Relationship: _____

RELEASE INFORMATION TO OUTSIDE PHYSICIANS

You have my permission to send medical information to the following physicians if requested by their office.
Please provide **both first & last name of each physician, phone number and specialty**.

DOCTOR NAME	PHONE	SPECIALTY
_____	_____	_____
_____	_____	_____
_____	_____	_____

RELEASE INFORMATION TO PHARMACY

You have my permission to send any prescriptions needed to the pharmacy listed below.
Pharmacy Name: _____ Pharmacy Phone: _____
Pharmacy Address: _____

_____ _____
(Patient Signature) (Date)

AUTHORIZATION FOR MAGOPSA TO COLLECT PERSCRIPTION MEDICATION HISTORY THROUGH EMR

I authorize MAGOPSA to access medication recognition history through EMR.

_____ _____
(Patient Signature (Date)

_____ _____
(Witness Signature) (Date)