Mid Atlantic
Gynecologic Oncology and Pelvic
Surgery Associates

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RELEASE OF PATIENT INFORMATION CONSENT FORM

PATIENT'S NAME: _____ **DOB:** _____ **SSN:** _____

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 numbers(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.

Name _____ At _____ Relationship: _____

Name _____ At _____ Relationship: _____

Name _____ 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 PRESCRIPTION MEDICATION HISTORY THROUGH EMR

I authorize MAGOPSA to access medication recognition history through EMR

_____ _____
Patient Signature **Date**

_____ _____
Witness Signature **Date**