



AN AFFILIATED PRACTICE OF

Yale Medicine

Greater New Haven
OB/GYN Group

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Patient Contact Authorization
Patient Confidentiality Authorization

Patient's YNNH Medical Record Number _____

Printed Name of Patient _____ DOB: _____

I authorize Greater New Haven Ob/Gyn Group to call me (and if I am not available leave a detailed telephone message) at any phone number, including any cell phone, listed below for the purpose of providing normal test results and appointment reminders (which we may provide via an automatic telephone dialing system of artificial or prerecorded voice):

Home _____

Work _____

Cell _____

Email Address _____

I give my permission to Greater New Haven Ob/Gyn Group to talk to the following people regarding my medical care; including the nature of my visit, test results, diagnosis, surgical procedures, medication, and any applicable billing questions.

Name _____ Phone # _____ DOB _____ Relationship _____

Name _____ Phone # _____ DOB _____ Relationship _____

Name _____ Phone #: _____ DOB _____ Relationship _____

Signature of Patient _____ Date _____

Signature of Parent/Legal Guardian/Patient's Personal Representative: _____
(If patient is under the age of 18 or otherwise incapable of signing)

Printed name of Parent/Legal Guardian/Patient's Personal Representative _____

Relationship: _____