



OB-GYN
A S S O C I A T E S

699 Church Street, Suite 300
Marietta, GA 30060

PROTECTED HEALTH INFORMATION FORM

PATIENT NAME

DATE OF BIRTH

PRIMARY PHONE NUMBER

CELL / WORK / HOME (CIRCLE ONE)

SECONDARY PHONE NUMBER

CELL / WORK / HOME (CIRCLE ONE)

MEDICAL INFORMATION AND/OR TEST RESULTS MAY BE:

GIVEN TO PATIENT ONLY

GIVEN TO THE FOLLOWING PERSON(S)

NAME

RELATIONSHIP TO PT.

NAME

RELATIONSHIP TO PT.

MESSAGES:

MAY BE LEFT ON VOICEMAIL

MAY **NOT** BE LEFT ON VOICEMAIL

SIGNATURE OF PATIENT

DATE