

Mid-Atlantic Pelvic Surgery Associates

Patient Information Release Form

PATIENTS NAME: _____

PATIENTS DOB: _____

To maintain patient confidentiality, we do not currently leave messages that have to do with labs results or information about prescriptions on voice mails or emails. In an effort to stop the "phone tag" and more efficiently convey test results to our patients, we offer the option of signing a **release of information form**. This would allow us to leave information on an answering machine or voice mail at any phone number(s) of your choice, so that you may get the information in the timeliest manner possible.

Please list the phone number(s) that is (are) best to contact you regarding test results or prescription information.

1. _____ 2. _____

3. _____ 4. _____

You have my permission to contact _____ at _____ whom I designate be informed of my medical care.

By signing below I give my permission to have the physician or the staff of Mid-Atlantic Pelvic Surgery Associates, P.C. leave information about test results or prescription on voice mail/answering machines that answers at the phone number(s) listed above in the event that I do not answer the phone. Or contact the name above that I have listed regarding information of my medical care in this office.

(Patient Signature)

(Date)

(Witness Signature)

(Date)

Please list any physicians that you would like us to keep informed, along with their specialty. Please provide **both first & last name and phone number**. Thank you.

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

PLEASE ENTER PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Gynecologic Oncology and Pelvic Surgery

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Annette Bicher, MD
John C. Elkas, MD, JD
Ruchi Garg, MD

Fellows

Addie Alkhas, MD
Caela R. Miller, MD
Jasmine Han, MD
Yovanni Casablanca, MD
Kevin Byrd, MD

Urogynecology and Reconstructive Pelvic Surgery

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