Perinatal Associates
of NEW MEXICO

I, _____ , have been offered a copy of
patient printed name
Perinatal Associates of New Mexico's Notice of Privacy Practices.

☐ I accept a copy of this Notice

☐ I decline a copy of this Notice

Signature of Patient: _____ Date: _____

VOICEMAIL AUTHORIZATION

☐ I, _____ , hereby give my permission for Perinatal Associates of New Mexico, Ltd. to leave a voicemail at the numbers provided by me regarding my medical care. This includes detailed medical information and test results.

☐ I, _____ , **DO NOT** authorize Perinatal Associates of New Mexico, Ltd. to leave a voicemail regarding my medical care.

Signature of Patient: _____ Date: _____

DISCLOSURE OF INFORMATION TO OTHERS

☐ I, _____ , hereby give my permission for Perinatal Associates of New Mexico, Ltd. to discuss appointment scheduling and medical information, including test results, with the following:

Name/Relation/Phone: _____
Name/Relation/Phone: _____
Name/Relation/Phone: _____

☐ I, _____ ,**DO NOT** give Perinatal Associates of New Mexico, Ltd. to speck to anyone aside from myself regarding appointment scheduling and medical information, including test results,

Signature of Patient: _____ Date: _____