Perinatal Associates
of NEW MEXICO

I,_____ , have received a copy of Perinatal
patient printed name

Associates of New Mexico's Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

I,_____ , hereby give my permission for Perinatal Associates of New Mexico, Ltd. to leave messages regarding my medical care with the following: *(Mark all that apply:)*

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

☐ Voicemail at numbers provided by patient

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

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

Authorized by: _____ Date: _____

Notice of Privacy Practices Receipt / Authorization to Leave Messages