FAR HILLS OB/GYN, INC.

David W. Shie, M.D. John M. Shie, M.D. Caroline H. Kennebeck, M.D.

Kelly L. McCluskey, M.D., LLC Shannon N. McAfee, D.O., LLC

STATEMENT OF RELEASE

The purpose of this form is to give the physicians and staff of these offices permission to release your medical information (such as lab or test results) to any person you designate when we are unable to reach you. This will also allow us to give your medical information to a family member who may call on your behalf. This consent will remain in effect until updated by you. Please read carefully and sign only one section.

I hereby AUTHORIZE the physicians and/or staff to release information pertaining to my patient file to the following person (s):

(NAME)	(RELATIONSHIP)
(NAME)	(RELATIONSHIP)
(NAME)	(RELATIONSHIP)

PATIENT SIGNATURE: _____ DATE: _____

****

I DO NOT authorize the physician and/or staff to release information pertaining to my patient file to any person (s):

PATIENT SIGNATURE: _____ DATE: _____

****

Messages may be left on my answering machine/cell phone/voice mail: Yes ( ) No ( )

Please feel free to ask questions you may have concerning this form.