Patient Account #_____

Acceptance of Blood Products

At Gwinnett OB/GYN we strive for optimum health and to preserve life. In the case of a life threatening emergency, **it is our policy to transfuse with blood if it is necessary to save your life.**

Please sign one of the below:

I understand and **agree** with the above transfusion policy.

_____

Print Name Signature Date

_____

Witness Signature Date

I **disagree** and will be transferring my care elsewhere.

_____

Print Name Signature Date

_____

Witness Signature Date

Updated 11/7/19

Gwinnett OB/GYN Associates, P.C.
1700 Tree Lane Road
Suite 290
Snellville, GA 30078

PATIENT'S CONFIDENTIALITY INSTRUCTIONS

Patient Name _____ **Acct#** _____

It is important for us to honor the confidentiality between patient and physician.
PLEASE CHECK YOUR PREFERENCE BELOW.

_____ **You may discuss my medical information ONLY with me.**

_____ **I give my permission to discuss my medical information with the following people:**

_____ **Relationship** _____

_____ **Relationship** _____

_____ **Relationship** _____

Yes or No (circle one) **You may leave medical information (test results) on my voice mail at:**

Cell # _____

Home # _____

Signed _____ **Date** _____