Women's Health Associates

Patient Name: _____ **Date of Birth:** _____/_____/_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I give permission for Women's Health Associates to provide any information about my medical condition, medical needs, medications or the status of my account to the following individual(s):

Name of Designated Person: _____

Relationship: _____ Phone Number: _____

Name of Designated Person: _____

Relationship: _____ Phone Number: _____

Name of Designated Person: _____

Relationship: _____ Phone Number: _____

☐ Patient Declined

Patient's Signature: _____ **Date:** _____/_____/_____

This consent will remain in effect until revoked by patient. Minor patients will be asked to complete this consent again once they reach 18 years of age.

CONFIDENTIAL COMMUNICATION REQUEST

From time to time, it is necessary to contact you by telephone for appointment reminders, test results or other information. Often our patients are not available when we attempt to contact and we would like to leave detailed phone messages. In order to protect your privacy we need your written permission to leave detailed phone messages on your answering machine or voice mail system.
Please choose one of the following:

☐ **I DO CONSENT** for Women's Health Associate to leave detailed messages on the home or cell number I provided. This will remain in effect until patient rescinds in writing.

- ☐ Home
- ☐ Cell _____

☐ **I DO NOT CONSENT** to leave detailed messages on my home or cell number.

☐ **REVOCATION OR PRIOR CONSENT**. I wish to rescind or stop the above authorization on this date _____.

Patient's Signature: _____ **Date:** _____/_____/_____