

HealthCare for Women

Patient Name: _____

Account Number: _____

Date of Birth: _____

I hereby authorize HealthCare For Women to disclose my medical/financial information to the following person/s:

Name:	Name:
Relationship:	Relationship:
Birth date:	Birth date:
Restrictions: (i.e. medical info only, financial info only)	Restrictions: (i.e. medical info only, financial info only)

TO OUR PATIENTS:

This authorization will remain in effect until you revoke or modify it in writing. Any persons not listed above will not be given access to your personal information unless you personally call and give verbal consent.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Patient: _____ Date: _____

