Patient's Authorization to Release Medical Information

I understand that my family members, friends, or other individuals may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of confidentiality to discuss my protected health information (PHI) in any way with anyone without my written consent. By signing this form, I am authorizing Women's Health Care to discuss my protected health information with only the individuals I have listed below.

I understand the information on this form will remain in effect until I update my information, **in writing**, with Women's Health Care. I understand it is my responsibility to inform Women's Health Care, **in writing**, of any changes I wish to make regarding the release of my medical information.

In accordance with the above, I, _____ hereby give authorization to discuss and release my medical information to the following individuals:

_____ _____

_____ _____

Furthermore, I understand that if there is any information in my medical record I do NOT want discussed with or released to the above, I must designate it here by stating what information is to be excluded.

_____

_____

Patient signature _____

Patient Name (Printed) _____

Patient Date of Birth _____

Signature date _____