For Women Inc.

AUTHORIZATION FOR RELEASE OF INFORMATION BY PATIENT

I understand that it is the policy of For Women Inc. (the Practice) to protect my privacy and to follow all state and federal privacy laws. However, I also understand in order to involve my parents, significant other or other individuals in my medical care it will be necessary for the Practice to use/disclose my Medical Information. I hereby specifically authorize the Practice to disclose such information to the persons listed below:

☐ **I authorize** For Women Inc. to release and discuss my Medical Information including test results and procedures to the following individuals:

Name:_____Relation to Patient:_____

Name:_____Relation to Patient:_____

Name:_____Relation to Patient:_____

☐ **I do not** authorize For Women Inc. to release or discuss my Medical Information with anyone.

IF THIS INFORMATION CHANGES, IT IS YOUR RESPONSIBILITY TO INFORM OUR PRACTICE OF THOSE CHANGES.

_____ _____

Patient Signature Date:

_____ _____

Print Name Birth Date

If I need to be contacted by the office in anyway regarding test results, procedures or with any medical information please contact me in this way:

☐ Home Telephone_____
- o OK to leave detailed message on machine
- o Leave message with call back Number

☐ Cell Phone_____
- o OK to leave detailed message
- o Leave message with call back Number

☐ Work Telephone_____
- o OK to leave detailed message on machine
- o Leave message with call back Number