**Physicians for Women, PC**
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# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

We must have your permission to discuss your treatment, medical or financial information, etc. with anyone other than yourself. If a person's name is not listed on this consent form, we cannot discuss your information with them.

What telephone number are we to call when trying to contact you? _______________ Do we have permission to leave a message on your telephone? ____________

## *PLEASE SIGN IN ONLY ONE OF THE AREAS BELOW*

I hereby give my consent for the physicians and staff of Physicians for Women, PC to review or discuss my medical treatment, laboratory results, pathology reports or financial information with the following persons ***other than myself*** (i.e. spouse, parent, child, interpreter, etc.)

1. ______________________________Relationship: ____________________Phone # ________________

2. ______________________________Relationship: ____________________Phone # ________________

3. ______________________________Relationship: ____________________Phone # ________________

4. ______________________________Relationship: ____________________Phone # ________________

Signature: ______________________________________Date: ____________________________________

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**DO NOT DISCUSS ANY INFORMATION TO ANYONE OTHER THAN MYSELF.**

We need a personal password for you. Your information will not be released over the telephone without you giving us your password. If you forget your password, you will need to make an appointment and come into the office. You are responsible for keeping you password private.

**PASSWORD:** ___________________________

Signature: ______________________________________Date: ____________________________________