PHYSICIANS FOR WOMEN OF GREENSBORO

PERMISSION TO COMMUNICATE

So that we may serve you better, you have the option of providing us with a list of people with whom we may discuss your health information. You are not required to provide a list. If no names are provided, our employees will not be able to discuss any issue related to your care with anyone but you.

I, ______________________________________ give consent to Physicians for Women to share health information with the people listed below should anyone contact us for information. I understand this allows Physicians for Women to share any of my health and/or billing information. If I do not want certain information shared, I have listed it in the space below.

NAME	RELATIONSHIP
_____________________________________	_____________________________
_____________________________________	_____________________________
_____________________________________	_____________________________

DO NOT RELEASE INFORMATION ABOUT:______________________________
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I, _______________________________________ give permission to Physicians for Women to use one of the following communication methods to provide information regarding my care. If not checked, a message to return our call will always be our normal method of communication when our office needs to rely information.

- Leave a detailed message on my home answering machine #_________________
- Leave a detailed message on my work voicemail #_________________________
- Leave a detailed message on my cell phone voicemail #_____________________
- Leave a detailed message with ____

(Name & Relationship)

I understand that I have the right to revoke this authorization at any time by giving Physicians for Women written notice. This authorization shall be in effect until revoked by the patient.

_____________________________________ _____________________________

Signature of Patient Date

_____________________________________ _____________________________

Print Name Date of Birth