Women's Health Alliance, P.A.
pka
WILKERSON OBSTETRICS & GYNECOLOGY

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CONSENT FOR RELEASE OF INFORMATION

This consent form is a part of your medical record. If at any time this information should change, it will be your responsibility as the patient to inform Wilkerson OB/GYN.

I, _____, authorize the doctors and staff at Wilkerson
(Name of Patient)
OB/GYN to release information in my chart to:

_____ _____
(Name) *(Relationship)*

_____ _____
(Name) *(Relationship)*

_____ _____
(Name) *(Relationship)*

_____
(Signature of Patient)

_____
(Date)

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OR

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I, _____, **do not** authorize the doctors and staff at Wilkerson
(Name of Patient)
OB/GYN to release any information in my chart to anyone except myself or any physician directly involved in my medical care.

_____
(Signature of Patient)

_____
(Date)