PHYSICIANS FOR WOMEN OF GREENSBORO

A DIVISION OF PIEDMONT HEALTHCARE FOR WOMEN, PA

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:_____

_____

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