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.

DO NOT RELEASE INFORMATION ABOUT:_____

_____

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient Date

_____ _____

Print Name Date of Birth