Women's Health, Inc.
691 Murphy Rd. Ste. 232
Medford, OR 97504
(541) 773-3018

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO FRIENDS OR FAMILY MEMBERS

Patient Name: _____ Date of Birth: _____

Social Security #: _____

I request Women's Health, Inc to release Protected Health Care Information to:

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

This request and authorization applies to: (please check circle below)

- o All health care information
- o Health care information relating to the following treatment, condition or dates: _____
  _____
  _____
- o Other: _____

I understand that this designation applies only to Women's Health, Inc..

Patient Signature: _____ Date Signed: _____

Revocation / Termination

I request to revoke/terminate the designation made above.

Patient Signature: _____ Date Signed: _____