

John K. Appelbaum, M.D. • Timothy C. Philpott, M.D. Gigi Maminta-Streiff, M.D. • Angela M. Reining, M.D. Jennifer A. Meyer, M.D.

## **Authorization of Release of Information**

## to Family and/or friends

Name of Patient:	Date of Birth		
I authorize Women's Care Consultants to release protected health information to the entities named below:			
Give information to spouse or partner:	YES	NO	N/A
Name of spouse or partner:			
Give information to a family member or friend, please list:			
NAME RELA	ATIONSHIP	PI	HONE NUMBER
Please list any restrictions regarding information to be released:			
Rights of Patient: I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Women's Care Consultants. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective immediately upon receipt of notification by this practice. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization:			
Signature of Patient or Legal Guardian		Date	