Authorization to Discuss Patients Medical Information

OB-GYN HEALTH CENTER
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Date: ______________________________

I, ____ give the OB-GYN Health Center permission to discuss my medical information with:

______________________________ ______________________
Name (Print) Relationship

______________________________ ______________________
Name (Print) Relationship

I understand that this Authorization to discuss my Medical Information expires twelve (12) months from the date of my signature.

____
Expiration Date: Month/Day/Year

______________________________ ______________________________ ____________
Patient Name Patient Signature Date

______________________________ ______________________________
Witness Date

authdiscusspt
REV 7/30/16