PHYSICIANS TO WOMEN, INC.

Medical Information Release Form

(HIPAA Release Form)

Name: ________________________________ **Date of Birth:** _____/____/_____

Release of Information

[] I grant permission to Physicians to Women to disclose my protected health information to the following individual(s). If anyone other than person(s) listed below should call or ask for information they will be denied. If I choose not to be released to anyone, then I am agreeing that I am the only that can receive my information.

[] Spouse____

[] Child(ren)______________________________________

[] Other____

[] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [] my home [] my work [ ] my cell Number:__________________ If unable to reach me:

[] you may leave a detailed message [] please leave a message asking me to return your call

The best time to reach me is (*day*)___________________ between (*time*)_________

Prescription

[] I agree that Physicians To Women, Inc. can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Signed: _______________________________________ Date: ____/____/_____

Witness: _______________________________________ Date: ___/____/______