

AHN Ob-Gyn Associates

Obstetrics & Gynecology

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In order to make communications concerning appointments and treatment easier, the law requires your consent to release medical information. Please list specific names of family members and/or friends that have permission to obtain information from this office regarding your diagnosis and medical care.

Name/Relationship _____

I do give permission for you to leave a message on my:

Home answering machine _____
Work voice mail _____
Cell phone _____

Patient name _____

Signature _____

Date _____

Signature of patient representative if patient is a minor or an adult who is unable to sign form

Relationship of patient representative to patient

revised 05/08