Femina Women's Center

DISCLOSURE OF MEDICAL INFORMATION

Acct# : ______________________________ DOB: ___________________________

PATIENT NAME:

I, _______________________________ give permission for the following
(Print name) individuals to have access to my medical information.

Name Of Person Authorized To Have Information:	Relationship To Patient:	Date:

Further, I agree that Femina Women's Center, P.A. is released from any liability with the disclosure of any and all information. I understand that this may include information regarding sexually transmitted diseases, HIV, mental or physical limitations and other protected class information. I further understand that I can revoke this authorization at any time with written notice to Femina Women's Center, P.A.

Signed, this the ________________ day of ____________________, 2________

Signed: ____

Witness: ____ Date: ____________