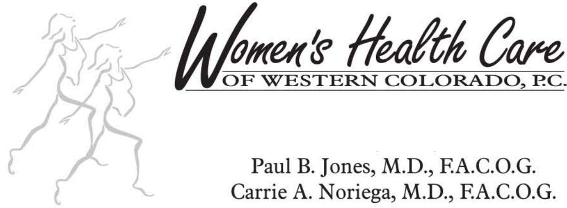

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PATIENT RELEASE OF INFORMATION

I,______________________________________, whose date of birth is _____-_____-_____,

authorize that medical information can be given by phone or in person to the following

individual(s):

Name	Relationship
______________________	______________________
______________________	______________________

This authorization expires one year from the date of this document or when rescinded by me.

______________________ ______________________
Signature Date

****

By my signature below, I request that messages from the office of Women's Health Care of Western Colorado, P.C. be left on my message recorder at my home number if I am not available to take a call personally. My telephone number is: ______________________________.

______________________ ______________________
Signature Date