Women First OB/GYN Center

PATIENT and MINOR CONSENT FORM FOR TEST RESULTS

AND HEALTH INFORMATION

Under the requirements for HIPAA we are not allowed to give information to anyone without the patient's consent. Please state in the space below any family members you wish to have medical information, any diagnostic test results and/or financial information released to, **not including physicians**. If you DO NOT wish to release information to anyone, please write "decline" then sign and date form.

I _____ give my consent to Women First OB/GYN Center to release both written and verbal confidential health information to:

Name	Relationship	Phone Number

_____ _____

Signature of patient Date

_____

Date of Birth