

MAETOZO TOTAL WOMAN'S CARE OF ST. AUGUSTINE, LLC

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I, (please print)	
Authorize Maetozo Total Woman's Care of St. Augus	stine, LLC
To release or discuss information related to my med treatment plan, medication information, and/or billi	
1)	
2)	
3)	
Please be advised that any person not referred to or care, including billing information. You may change,	n this list will not be given any information related to your , restrict, or expand this listing at any time.
You are not required to list any name, if you do not	so choose.
 Signature	 Date