

# Authorization to Discuss Patients Medical Information

## OB-GYN HEALTH CENTER

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769 N. Clyde Morris Blvd

Daytona Beach, FL 32114

386-258-0123

Date: \_\_\_\_\_

I, \_\_\_\_\_ give the **OB-GYN Health Center** permission to discuss my medical information with:

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Relationship

I understand that this Authorization to discuss my Medical Information expires twelve (12) months from the date of my signature.

\_\_\_\_\_  
Expiration Date: Month/Day/Year

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date