# Authorization to Discuss Patients Medical Information


## OB-GYN HEALTH CENTER

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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

Y:authdiscusspt
REV 01/23