Women's Care a Division of Mid-America Physician's Services LLC

Consent to Disclose Protected Health Information

I, _____, give my permission to disclose my health information to the following people listed below. I have the right to change, update or revoke this information at any time. This consent is effective for one year from the date signed, however, for your protection you will be required to update this form anytime changes need to be made. You must sign, put your date of birth and the date this form is completed at the bottom of this page for us to use this document for any reason to contact you or those listed.

Name _____ Name _____

Relationship_____ Relationship _____

Phone _____ Phone _____

- I understand that the information disclosed as directed above by Women's Care may be re-disclosed to additional parties and is no longer protected for reasons beyond our control.
- You have the right to receive a copy of this consent if requested.
- Completion of this consent is not a condition for treatment.

Listed below are telephone numbers that can be used to contact me, or for us to provide messages. Messages may include test results, as well as appointment and payment information.

My telephone numbers Ok to LM

#1 _____ Y N

#2_____ Y N

Email address _____

Pharmacy Information

Pharmacy name _____

Address _____

Phone _____

Signature _____

Date of Birth _____ Date _____