Seasons Women's Care

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Phone: (561) 328-6165 Fax: (561) 328-6091

OPEN AUTHOIRZATION TO RELEASE MY MEDICAL INFORMATION TO A FAMILY MEMBER/FRIEND

Patient Name:_____ DOB:_____

Address: _____

City:_____ State:_____ Zip: _____

I, _____, hereby authorize Seasons Women's Care to release any and all Protected health Information (PHI) maintained in my Medical record to the below listed individual(s). This includes patient status, treatment or financial inquires provided by Seasons Women's Care.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____

This authorization is valid until year 20_____ unless revoked by me. (a year is required) I may revoke this authorization at any time. Individuals listed on this form will be able to receive any and all information related to my status as a patient, treatment and payments during the time period stated above. Individuals not listed above will not be authorized to receive any information pertaining to my services by this facility. I am therefore releasing Seasons Women's Care from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

_____ _____
Patient's Signature (or Personal Representative) Date

_____ _____
Relationship to Patient Date

_____ _____
Witness Date