A WOMAN'S PLACE

1660 Medical Blvd, Suite 300
Naples, Florida 34110

Date: _____

I DO give A Woman's Place my permission to discuss pap, pathology, and lab testing or any other protected health information with the following:

_____ _____
Name Relationship

I DO give A Woman's Place my permission to discuss billing/payment information with the following:

_____ _____
Name Relationship

I DO give A Woman's Place my permission to access my medication list from pharmacy databases. This will insure that my health care providers have my most updated medication list on file at all times.

Yes **No**

May we leave a message on your answering machine at home concerning pap, pathology, lab testing or any other protected health information?
YES NO

May we leave a message at home confirming or canceling an appointment?
YES NO

May we leave a message at your place of employment to have you return our call?
YES NO

I understand that I can change or rescind this authorization at any time.

_____ _____
Printed Name of Patient Signature of PATIENT

_____ Witness from A Woman's Place