Center for Urogynecology & Female Pelvic Health
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physicians/staff of the Center for Urogynecology & Female Pelvic Health to release/leave medical information with the following: (check all that apply)

☐ Spouse/Significant Other Name: _____

☐ Family Member Name(s):_____

☐ Leave Message on Answering Machine

I understand and acknowledge that should I need to change how I receive my medical information, it will be necessary to notify my provider/office of those changes.

_____ _____ _____

Patient/Responsible Party Signature **Print Patient/Responsible Party Name** **Date**