MEDICAL WAIVER

This is to authorize my medical provider & related medical personal at ADVANCED OB/GYN to speak with the people listed specifically below and to discuss with them the medical treatment I have been receiving from her/him and the above clinic and any other matters related to that medical treatment.

This authorization shall remain in effect until such time as it is withdrawn by me, in writing, regardless of the date signed.

CONTACT_______________________________________**RELATIONSHIP**_________________________

CONTACT_______________________________________**RELATIONSHIP**_________________________

CONTACT_______________________________________**RELATIONSHIP**_________________________

DATE THIS THE _________**DAY OF** ______________________, **20**______

SIGNED____

WITNESS____

COMMUNICATIONS REGUARDING MY ACCOUNTS WITH ADVANCED OBSTETRICS & GYNECOLOGY

UNTIL my accounts are paid in full, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as cell phone, landline, or text number that I provide, auto dialer systems, voicemail messages and other forms of communications.

PATIENT____**DATE**___________________________

RESPONSIBLE PARTY_______________________________________**DATE**_________________________

WITNESS____**DATE**_____________________________