Women's Healthcare Physicians of Naples

11181 Health Park Blvd., Ste 2277, Naples, FL 34110
775 1st Ave N. Naples, FL 34102

PATIENT AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Date: _____

I DO give Women's Healthcare Physicians of Naples my permission to discuss Pap, pathology, and lab testing or any other protected health information with the following:

_____ _____
Name Relationship

I DO give Women's Healthcare Physicians of Naples my permission to discuss billing/payment information with the following:

_____ _____
Name Relationship

I DO give Women's Healthcare Physicians 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 cancelling 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