WOMEN'S EXECUTIVE HEALTHCARE, P.C.
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HIPAA FORM

____ I give permission for the following individuals to have access to my medical information:

	NAME	RELATIONSHIP
1.	___________________________________	____________________________
2.	___________________________________	____________________________
3.	___________________________________	____________________________
4.	___________________________________	____________________________
5.	___________________________________	____________________________

_____ I would like all of my medical information pertaining to my care at Women's Executive Healthcare PC to remain confidential. (I do understand if another physician who is participating in my care needs information relevant to my care, this information may be provided without a written consent).

I understand any changes I wish to make regarding the confidentiality of my medical information must be made by completing a new form, in person.

____ ____________________________

Patient Name Date of Birth

____ ____________________________

Patient Signature Date

____ ____________________________

Office Signature Date