Women's Healthcare Associates

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PATIENT CONTACT INFORMATION

Please indicate the telephone numbers that we can reach you and how you would most like to be contacted. This will help ensure that you receive all results or communication from us in the most efficient and timely manner possible.

___ **Home Phone** _____
_____ **O.K. to leave message with detailed information.**
_____ **Leave message with call back number only.**

___ **Cell Phone**_____
_____ **O.K. to leave message with detailed information.**
_____ **Leave message with call back number only.**

___ **Work Phone**_____
_____ **O.K. to leave message with detailed information.**
_____ **Leave message with call back number only.**

___ **Other** _____

I hereby consent to the release of my Protected Health Information to the following individuals. I understand this authorization will be effective until which time it is revoked.

NAME	**RELATIONSHIP**
_____	_____
_____	_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate