PATIENT CONTACT INFORMATION SHEET

Women's Medical Center of Meridian, P.A.

Patient Name: _____ DOB: _____

Social Security #: _____

Any physician, staff member, employee, or representative of WOMEN'S MEDICAL CENTER OF MERIDIAN, P.A., has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnoses, test results, medications, or any other types of protected health information, with the following persons in order to facilitate and coordinate my care, treatment, and payment:

Name	Relationship to Patient	Phone Number(s)
Name	Relationship to Patient	Phone Number(s)
Name	Relationship to Patient	Phone Number(s)
Name	Relationship to Patient	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to WOMEN'S MEDICAL CENTER OF MERIDIAN, P.A., or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s), it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

☐ Copy available to patient upon request.