

Physicians for Women Clinics

AUTHORIZATION TO LEAVE VOICEMAIL OR MESSAGE

Patient Name	Date of Birth	
I hereby authorize medical providers and personne or message at the designated phone number listed my protected health information.		
Voicemail can be left at this phone number:		
Also, a message for me may be left at this number:		with
(Relationship)	my	I understand this
message may contain my protected health informa	tion.	
I understand that certain information cannot be releaderal law. By initialing the lines below, I authorized information: Information regarding the patient's company to the patient company to the pat	e the release of the following p diagnosis and treatment for HI' crist or psychotherapist	protected or sensitive
This authorization shall be in force and in effect for at which time this authorization expires. OR Indefinitely - This authorization to use or discovery of the standard of the standard that I have the right to revoke this authorization is not effective to the protected health information. I understand that the information used or disclosed precipient and may no longer be protected by federal of I understand that I have the right to refuse to sign this	isclose this protected health is prization in writing at any time. The extent that the Clinic has relied or cursuant to this authorization may be prostate law.	nis protected health Information with not expire. In the use or disclosure of the
Turiderstand that I have the right to refuse to sign this	3 441.101.1241.0111	