GynoFitMD
Women's Health & Medical Weight Loss Expert

Medical Information Authorization

Last Name: _____ First Name: _____ DOB: _____

I understand that information will only be shared with those involved with the maintenance of my care and individuals that I provide the office permission to speak with regarding results or my medical information.
Please list all names and phone numbers of individuals you allow our office to release information to if needed:

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

This authorization is valid from _____ to _____
(Start Date) *(End Date)*

☐ I decline to list any authorized individuals to receive information about my care/results.

Please indicate which information can be disclosed:		
☐ All Records	☐ Operative Reports	☐ Mammograms
☐ Lab/Pathology Reports	☐ Progress Notes	☐ Medication Log
☐ H&P	☐ Ultrasounds	☐ Pap Smears
☐ Other:		

Patient or authorized representative signature: _____ Date: _____

GynoFitMD Staff Witness: _____ Date: _____