AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name_____

Date of Birth_____ Social Security #_____

I authorize All About Women of Christiana Care, Inc. to disclose my health and medical information to the following individuals: (If you do not want anyone to have access to your information, please write "do not release")

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that I may revoke this authorization at any time. The revocation must be in writing and submitted to All About Women of Christiana Care, Inc. This authorization permits All About Women of Christiana Care, Inc. to release your medical information and test results to the persons specified above.

_____ _____

Patient Printed Name Date

_____

Patient Signature