To:_____

_____

_____

This will be authority any my consent for you to release all information, history and data, confidential and otherwise, which you may have pertaining to the treatment or knowledge of my state of health at any time to:

All About Women of Christiana Care, Inc
MAP Building II
4735 Ogletown-Stanton Road
Suite 2300
Newark, DE 19713

Patient Signature:_____

Patient Name:_____

Patient Address:_____

_____

_____

Patient SS#:_____

Date:_____