Associates in Women's Health Care

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RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS

I authorize Associates In Women's Health to discuss and release all medical information to family members named below, including medical records, x-rays, history, findings and prognosis pertaining to the medical condition, services rendered, or treatment given to me. This authorization complies with the confidentiality of Medical Information Act, section 56 et seq. of the California Civil Code.

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Name **Relationship to patient**

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Name **Relationship to patient**

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Name **Relationship to patient**

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Name **Relationship to patient**

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Patient Signature **Date**

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