TRI-STATE PERINATOLOGY
JOINTLY PHYSICIAN OWNED
at The Women's Hospital

PERMISSION TO DISCUSS MY CARE

Patient name	Birthdate

I permit the following information to be discussed with those of my family, friends or others listed below. I understand that if I want any of these persons to receive a copy of my records, I must complete and sign a separate 'Authorization' or 'Release of Information' form. Copies of my complete record can be obtained through the Medical Records Department. Copies of individual test results or office notes can be obtained from the physician office.

☐ Appts only
☐ Results/Plan of care
☐ My bill

Name	Relationship	Phone

☐ Appts only
☐ Results/Plan of care
☐ My bill

Name	Relationship	Phone

☐ Appts only
☐ Results/Plan of care
☐ My bill

Name	Relationship	Phone

☐ Appts only
☐ Results/Plan of care
☐ My bill

Name	Relationship	Phone

Discussion of results and plan of care will not include mental health counseling sessions for which a separate form is required.

In an emergency or if admitted to the hospital and unable to make my wishes known, I understand that my doctor and hospital staff may rely on the above permission to determine with whom they may discuss my care.

The above permissions can be changed by me at any time by notifying my doctor's office, Medical Records or The Women's Hospital Privacy Officer.

Patient Signature	Date
Printed Name	
Signature of lawful personal representative*	Telephone