WOMEN'S CARE SPECIALISTS, P.C.

PATIENT AUTHORIZATION

As a patient of Women's Care Specialists, P.C., I ______________________ hereby give my consent to the following persons or person listed below to discuss any and or all of my medical history in the event that I am unable to be reached or if I become incapacitated.

I authorize the release of any test results to my primary care physician, Dr. ____________________. I also authorize Women's Care Specialists, P.C. to leave a message on my voicemail concerning test results and appointment reminders. I understand that this authorization will remain in effect until written authorization for changes is received from me. I understand that the physicians not the staff of Women's Care Specialists, P.C. will not be held liable for unauthorized individuals impersonating me or listening to my voicemail.

______________________________ ______________________________

______________________________ ______________________________

Patient Signature_____________________________ Date____________________