Lake Obstetrics and Gynecology, Inc.

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CONSENT TO DISCLOSE MEDICAL INFORMATION

I, _____, give permission to the doctors and the
(print name)

staff of Lake Obstetrics and Gynecology to disclose any of my medical information to the following person/people. This includes, but may not be limited to, information about my care, condition, test results, and appointment times. This permission will stay in effect until I revoke it in writing.

YES **NO** You may leave a message for me with the following person/people:

Name/Relationship	Phone Number
_____	_____
_____	_____
_____	_____

YES **NO** You may leave a detailed message on my answering machine at

_____ *(phone number)* or on my cell phone at

_____ *(cell phone number)*.

YES **NO** You may contact me via email, if necessary, at

_____ (email address).

_____ _____
(signature) *(date)*