The Women's Group of Gwinnett, P.C.
500 Medical Center Blvd
Suite 250
Lawrenceville, GA 30046

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize The Women's Group of Gwinnett to contact me at the following places:

Home telephone/answering machine	yes	no
Cell phone/voice mail	yes	no
Work telephone	yes	no

_____You may discuss my medical information ONLY with me

_____ I give my permission to discuss my medical information with the following people:

_____Relationship_____

_____Relationship_____

_____Relationship_____

Please list names of people with whom we may discuss your financial information:

_____Relationship_____

_____Relationship_____

YES or NO You may leave medical information (test results) on my voice mail at:

Cell #_____ Home #_____

_____
Name: please print

_____ _____
Signature of Patient/Guardian Date: