C O V I N G T O N
WOMEN'S HEALTH
S P E C I A L I S T S
4181 Hospital Dr. NE. Suite 101 & 104, Covington, GA 30014
5154 Cook Street NE, Covington, GA 30014
PHONE: 770-385-8954 FAX: 770-385-8590

Consent To Release Information

The HIPAA Privacy act prevents us from disclosing information about you to others. Therefore, if you would like us to share any information with others (including family members) regarding your information please enter the required information and sign the form below. Unless this is signed, we cannot give information to anyone, including acknowledging that you are a patient.

I, ________________________________ give permission to Covington Women's Health Specialists, LLC to release and share information regarding my health status to the following person/people:

1. ____relationship_____________________

2. ____relationship_____________________

3. ____relationship_____________________

This consent covers all aspects of medical care.

Agreed to this ___________________day of _____________________, ________________
(month) (year)

_______________________________________ _____________________________
Patient's Signature Date of Birth

_______________________________________ _____________________________
Print Name Date

____
Witness