Women Physicians In OBGYN, Inc.

COMMUNICATION CONSENT

Date:_____

I, _____, give my consent to allow any staff member of
Print name

Women Physicians In OBGYN, Inc. to discuss my medical information and or treatment with the following individuals:

First Name (print)	Last Name	Relationship to patient
1.		
2.		
3.		
4.		
5.		
6.		

Signature_____Date of Birth_____