CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION TO PERSONAL REPRESENTATIVES

Name:	
Address:	
City, State & Zip:	
Phone Number:	
SS#	
Date:	

I, ________________________________, give my written consent for Physicians and Surgeons for Women, Inc. to share information regarding my protected health information and care to the following listed persons; I understand that these persons may be treated as personal representatives of myself.

Personal Representatives that you may share my health information with:

____
(Name) (Relationship)

____
(Name) (Relationship)

____
(Name) (Relationship)

You may leave a message: (please check all that apply)
_____ At Home _____ At Work _____ on answering machine

Verification Data: ____
(Mother's maiden name or other ID we can use)

____ ____
Patient's Signature Witness Signature

____ ____
Date: Date:

____ do not discuss my information with anyone other than myself at any time
* (Must complete "Request for Confidential Communication of Protected Health Information" form