COMPLETE
WOMEN'S CARE OF ALABAMA

Communication Authorization Form

Patient Name: _____

Social Security Number: _____

Any physician, employee, or representative of Complete Women's Care of Alabama PC has my permission to verbally discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following person(s) in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

❑ **I do not wish to have test results or other medical information released to anyone other than myself.**

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Complete Women's Care of Alabama PC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals, it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____