OBGYNASSOCIATES

OB-GYN Associates P.C.
45 East 85th Street, New York, NY 10028

PATIENT CONSENT TO RELEASE MEDICAL INFORMATION

I,__________________________ give my permission to Dr. __________________________ to discuss my care, treatment and results with the following people:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

This will remain in effect until I advise otherwise.

Signed ____

Date ______________________________________

Witness ______________________________________