MERCY CLINIC OBSTETRICS AND GYNECOLOGY

In our office we will do everything possible to maintain your privacy. Please help us do this by filling out this form.

I, ___________________________________, give permission for you to discuss my medical condition, results and care with the following person(s) specified below.

Names(s) and relationship:

____

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Please mark all that apply:

_____ I do not want my medial condition discussed with anyone other than myself.

_____ I give permission for you to leave a message on my answering machine at home.

_____ I give permission for you to leave a message on my cell phone voicemail.

_____ I give permission for you to leave a message on my answering machine at work.

Signature:____ Date:__________________________________

Print Name: ____

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