

PHYSICIANS FOR WOMEN, P.C.
880 EASTPORT CENTRE DRIVE, SUITE 200
VALPARAISO, IN 46383

CONSENT TO RELEASE INFORMATION

I, _____, authorize Physicians For Women, P.C. to discuss my care and treatment with, and to release any and all medical and incidental information to _____.
(Name) (Relationship) This consent is for present and future medical care and treatment and will remain in full force and effect until revoked in writing by me.

Patient

Date

Witness

Date