Women's Health
& Family Care

S. Douglas George, MD
Laura Vignaroli, MD
Giovannina Anthony, MD
Kathryn Noyes, MD

P.O. Box 14230, Jackson, WY 83002
Phone 307-734-1313 ~ Fax 307-734-0314
Tax ID: 46-1497992

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Records From:_____

Attention: _____

Mailing Address: _____

Phone#:_____

FAX#: _____

Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Full Name:_____ Date of Birth:_____

Maiden Name and/or Alias (IF applicable):_____

This authorizes that medical information regarding the above identified person be forwarded to:

Women's Health Center & Family Care Clinic, llc
P.O. Box 14230
Jackson, WY 83002

Phone# 307-734-1313 ~ Fax# 307-734-0314
Email: whfcjackson@gmail.com

Concerning treatment from: _____

I hereby consent to the release of the above information. I release the above named person(s) and my attending physician(s) from all liability and all claims of any nature whatsoever pertaining to disclosure of information concerning the above named patient.

There are no limitations placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for conditions pertaining to alcohol and/or drug abuse, mental disorders or sexually transmitted diseases; including Acquired Immune Deficiency Syndrome (AIDS).

This authorization is valid for twelve (12) months unless revoked earlier in writing.

Signed: _____**Date:**_____

IF signed by other than patient:
Relationship to Patient _____

Patient unable to sign due to: _____

A photocopy of this authorization shall be considered as valid as the original.