Patient Record of Disclosures

Please fill out completely

Patient Name:	**Date of Birth:**

Who may we release medical information to:

Name: ____
Relationship to you:___________________________

Name: ____
Relationship to you: ___________________________

Name: ____
Relationship to you: ___________________________

I wish to be contacted in the following manner (check all that applies):

- ☐ **Home Telephone** ____
  - Okay to leave message with detailed information
  - Leave message with call back number and name of Barton Women's Health only

- ☐ **Work Telephone** ____
  - Okay to leave message with detailed information
  - Leave message with call back number and name of Barton Women's Health only

- ☐ **Cellular Phone** ____
  - Okay to leave message with detailed information
  - Leave message with call back number and name of Barton Women's Health only

- ☐ **Other** ____

Signature __________________________________ ***Date*** _______________