MedStar Health

MedStar Health OB/GYN

Patient Name: _____ (Printed)

D.O.B: _____

This is to notify the Department of Obstetrics and Gynecology at MedStar Health that I grant permission for all Doctors, Nurses and other staff members of the Department of Obstetrics and Gynecology as well as family members or friends to communicate freely about my medical condition in person, on the telephone, or in writing with the following individual(s):

***OPTIONAL**

Name	D.O.B.	Relationship/Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Unless otherwise indicated, this permission will expire one (1) year from the date below.

*** I also grant permission for messages to be left (for me) on the following phone number(s) to reach me for the following:**

Appointments _____ Test Results _____ Prescriptions _____

Cell _____ Home _____ Work _____

Signature _____ Date _____