Prince William OBGYN

PERMISSION TO AUTHORIZE TREATMENT OR RECEIVE INFORMATION

Patient Name: ____ Date of Birth: ____________

Social Security Number: ________________________________

I hereby give my permission to the person(s) listed below to authorize treatment and to receive information about the care of the above named patient.

NAME	RELATIONSHIP
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

__________________________________ ____________________

Signature of Patient, Parent or Guardian Date

This authorization will expire on____________________. If no date is listed, it is understood that the authorization will remain in effect until a new Permission to Authorize Treatment is executed.

In order to obtain information by telephone, the party calling the practice must share the patient password with our staff. My patient password is:____________________________________.