

*Progressive Women's Health, P.A.*

6072 Doctor's Park Rd.

Phone 850-983-3528

Milton, FL 32570

Fax 850-983-3546

**PATIENT CONTACT INFORMATION SHEET**

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Any physician, staff, employee or representative of Progressive Woman's Health, P.A. has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following person(s) in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Progressive Woman's Health, P.A. or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_