AUTHORIZATION TO RELEASE INFORMATION

I give my permission to Her Health OBGYN to discuss with:

INDIVIDUAL'S NAME	RELATIONSHIP TO PATIENT

All aspects of my care, including but not limited to, billing information, reasons for my visits, dates of appointments and treatment. I understand that this may include highly personal and sensitive information. **I understand that I am giving up my right to confidentiality with regard to this individual** until such a date that I may reverse this release in writing to Her Health OBGYN.

SIGNATURE OF PATIENT	DATE

CLEARLY PRINT PATIENT'S NAME	BIRTHDATE