Baldwin Woods OB/GYN

Women's Advanced Health & Wellness

I, the undersigned, do hereby consent and request that Baldwin Woods OB/GYN communicate with or release health information concerning me if said communication is in my best interest and is only information that is directly relevant to designated individuals' involvement with my healthcare and treatment decisions.

Patient's name: x_____

Date of birth: x_____

Voicemail: ____ Text Message: ____

-If you do not wish for anyone aside from healthcare professionals to have access to your treatment information, please check here:

-I do not grant consent for anyone to be given information regarding my care or treatment except required by law- ☐

1. Name and address of person who I want to have health information as outlined above

Name _____ Relationship to Patient _____

Phone: _____

Voicemail: ____ Text Message: ____

2. Name and address of person who I want to have health information as outlined above

Name _____ Relationship to Patient _____

Phone: _____

Voicemail: ____ Text Message: ____

3. Name and address of person who I want to have health information as outlined above

Name _____ Relationship to Patient _____

Phone: _____

Voicemail: ____ Text Message: ____

_____ _____

Signature Date Printed Name