

Date:	
I,	give permission for Dr
(patient name)	
and her staff to talk with	, my
	(name)
, about my	medical condition.
(relationship) This information may:	
(please initial) include HIV (AII disorders/mental health, or drug and/or alco	DS virus), Sexually transmitted diseases, psychiatric shol use.
(please initial) NOT include Hidisorders/mental health, or drug and/or alco	IV (AIDS virus), Sexually transmitted diseases, psychiatric shol use.
I understand that this authorization will be ş	good from/to
/ If at any time thi	is authorization changes, I understand that I will need to give
written notice of that change.	
Patient's Signature	Date
Witness	Doctor's Signature

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