I have read the Privacy Notice and understand my rights contained in this notice.

As indicated by my signature below, I provide Elite Women's Care Center, PA with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient's Name (print) ___________________________________ Date ________________

Patient's Signature _____________________________________ Date _________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER

Name of Patient:____ DOB:________________

I hereby authorize Elite Women's Care Center to discuss my protected health information with the following friend(s) and family member(s):

Name__________________________________Relation_________________DOB__________

Name__________________________________Relation_________________DOB__________

Name__________________________________Relation_________________DOB__________

Name__________________________________Relation_________________DOB__________

______________________________________ ___________________________________

Patient signature **Date**