Permission to Share Health Information with Family/Friends

Patient Name _____

Date of Birth _____

I hereby authorize the Perinatal Center to release any information and/or test results to the following:

Name _____ Relationship _____

Name _____ Relationship _____

By signing this paper I give permission to the above person(s) listed to receive information about my care. I understand my healthcare provider will use their professional judgment to ensure that the information is shared with those listed above in order to assist with my continuing care.

_____ _____

Signature of Patient or Legal Guardian Date and Time

HCA Va
An HCA affiliate

The Perinatal Centers
PERMISSION TO SHARE INFORMATION

NNS

PATIENT LABEL