Joanne Goshow-Harris, D.O. Helen McCullough, D.O. A. Diane McCracken, M.D. Dina Anderson, MSN, RNC
Jennifer Barlow, M. D. Christine Maynard, M.D. Clare Szymanski, CNM, WHNP, MSN, APN
Karen M. Earl, M.D. Ashley August, PA-C Molly A. Larkin, M.D. Regina Smith, D.O.
Heike Kuehn, APN, MSN Natalie Chavez, M.D. Casey Bedder, D.O. Michele LaMarr-Suggs, CNM
Patricia Ciranni, WHNP, MSN, APN. Nancy Welch, WHNP

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2600 Glasgow Avenue * Suite 120 * Newark, DE 19702

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name_____

Date of Birth_____ Social Security #_____

I authorize All About Women, P.A. to disclose my health and medical information to the following individuals **other than myself**: **(Do not list physicians; they are covered under your HIPAA privacy practice notice. If you do not want anyone to have access to your information, please write "do not release".**
This form allows All About Women, P.A. to discuss medical findings with the individuals listed below unless otherwise noted.

PLEASE DO NOT LEAVE BLANK.

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that I may revoke this authorization at any time. The revocation must be in writing and submitted to All About Women P.A. This authorization permits All About Women, P.A. to release your medical information and test results to the persons specified above.

_____ _____
Patient Printed Name Date

_____
Patient Signature