

WOMEN'S CARE SPECIALISTS, P.C.

PATIENT AUTHORIZATION

As a patient of Women's Care Specialists, P.C. , I _____
hereby give my consent to the following persons or person listed below to
discuss any and or all of my medical history in the event that I am unable to be
reached or if I become incapacitated.

I authorize the release of any test results to my primary care physician, Dr.
_____. I also authorize Women's Care Specialists, P.C.
to leave a message on my voice mail concerning test results and appointment
reminders. I understand that this authorization will remain in effect until
written authorization for changes is received from me. I understand that the
physicians nor the staff of Women's Care Specialists, P.C. will not be held liable
for unauthorized individuals impersonating me or listening to my voice mail.

Patient Signature

Date