



RELEASE OF MEDICAL INFORMATION

Please understand that your medical information will be shared with your primary care physician or the physician who referred you to our office and others in the medical field who will be taking part in your healthcare.

However, in the event your spouse, children, family members or friends contact Dr. Venus, Teresa Tharpe, GONP, or a member of the BLUE RIDGE WOMEN'S CENTER staff, we will NOT be able to discuss anything with them unless they are listed below. It is NOT necessary to write a name on each line unless you feel those people might inquire about you and you give authorization to release the information. Please list the names below:

1. _____
2. _____
3. _____
4. _____
5. _____

If you prefer Blue Ridge Women's Center does NOT release any information to family or friends, please indicate such by checking this box.

This will become effective upon your signature below and it will be your responsibility to notify us of any change you wish to make to the above list of individuals.

Printed Patient Name: _____

Patient Signature: _____

Blue Ridge Women's Center Witness: _____

Date Signed: ____/____/____

Thank you in advance for helping us protect you and your medical information.