

## AUTHORIZATION TO RELEASE INFORMATION

I give my permission to Womens Care Center of Columbus, Inc. to discuss with:

\_\_\_\_\_  
INDIVIDUAL'S NAME

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

all aspects of my care, including, but not limited to, billing information, reasons for my visits, dates of appointments, and treatment. I understand that this may include highly personal and sensitive information. **I understand that I am giving up my right to confidentiality with regard to this individual** until such a date that I may reverse this release in writing to Womens Care Center of Columbus, Inc.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print patients name