



*Partners for
Women's Health*

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Meeting the Changing Health Needs of Women

_____ I give permission to release medical information to:

(indicate person's name)

_____ I give permission to release only the specific medical information to:

(indicate specific information)

(indicate person's name)

_____ I do not give permission to release medical information to:

(indicate person's name/relationship)

Patient Name: _____ Date of Birth: _____
(please print)

Patient Signature: _____

Date: _____