CONCORD OB/GYN

The exceptional care you deserve

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COMMUNICATION CONSENT

Date _____

I, _____, DOB ____/____/____ authorize Concord OB/GYN clinicians and staff to speak with and/or release information about my medical care to the following contact of my choice. I understand that I may revoke this consent at any time.

_____

Contact Name – PRINTED

_____

Contact Phone Number

_____

Relationship to Patient

_____ _____

Patient Signature Date