



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