

**STEAMBOAT SPRINGS WOMEN'S CLINIC**

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The Purpose of this form is to authorize Steamboat Springs Womens Clinic to share your medical information with a person you designate (e.g. your partner, a relative cousin or sister, or a friend. You can appoint several persons if you want to, or leave it blank, if someone calls or comes here to ask for any information about you, the name of this person must be on this form, if not, we can not give any information.

I, \_\_\_\_\_, Give my authorization for SSWC to give any

(Print Full Name)

medical information to the following person(s):

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\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**