Truesdale OB/Gyn, PC
1030 President Avenue
Fall River, MA 02720

To protect the privacy of our patients we request that you supply us with any and all persons that you authorize us to discuss your medical care with. Please list:

Name:	Relationship	Date	Phone #

I hereby authorize Truesdale OB/Gyn to be able to leave messages on my answering machine/voice mail regarding test results.

This will remain in force until otherwise instructed in writing by you.

Print patient name:_____ **Date:**_____

_____

Patient Signature