



Mesa Midwives

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Certified Nurse Midwives

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PATIENT RELEASE OF INFORMATION

I, _____, whose date of birth is ____-____-____,
authorize that medical information can be given by phone or in person to the following
individual(s):

Name

Relationship

This authorization expires one year from the date of this document or when rescinded by me.

Signature

Date

By my signature below, I request that messages from the office of Women's Health Care of
Western Colorado, P.C. be left on my message recorder at my home number if I am not
available to take a call personally. My telephone number is: _____.

Signature

Date