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Date: _____

I, _____ hereby authorize About Care OB/GYN Associates, P.C. and / or their representatives to release any and all information pertaining to my health care, including test results, procedures, billing and / or accounting information to the following person(s) or agencies.

- | | | |
|------------------------------------|---|---------------------------------|
| <input type="checkbox"/> Myself | <input type="checkbox"/> Parents | <input type="checkbox"/> No one |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Other (Please specify) _____ | |

I further authorize the physicians and their representatives to release the results of my medical exams in one or more of the following ways:

(please check all that apply)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> May Call Me | <input type="checkbox"/> Mail |
| <input type="checkbox"/> At Home | <input type="checkbox"/> May NOT Call Me |
| <input type="checkbox"/> Work | |

May leave a message to return call to physician's office: At Home At Work

Voice Mail None

I understand that this office will NOT release any' information to those persons who I have determined may not receive this information without a separate consent. I also understand that this relates to all medical as well as account information. If I wish to make changes to the status of this form, I will do so in writing.

Patient's Signature

Date