

**About Care GYN Associates, PLLC**  
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**Authorization for Information Release**

I, \_\_\_\_\_ hereby authorize

(please print full name clearly)

About Care GYN Associates, PLLC / Lillian M. DeCosimo, M.D. 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.

Please check all that apply:

Myself  Other: (Please specify): \_\_\_\_\_

**NO ONE** \_\_\_\_\_

I further authorize the physician and her representatives to release the results of my medical exams in one or more of the following way(s):

- May call me :**
- Home phone  Cell phone
- May **Email** me at: \_\_\_\_\_
- May leave a message to return call to physician's office:**
- At Home  At Work  Cellphone

**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 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.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_