Patient Name:____Date of Birth:______________

I hereby DO authorize permission for Dr. Cain, Teri Mizer CNP, Jessica George CNM, Jessica Costa, CNM and/or the staff at Twin Springs Ob/Gyn to release my medical information to:

_____ Spouse:____Date of Birth:________________

_____ Mother:____Date of Birth:________________

_____ Father:____Date of Birth:________________

_____ Other:____ Date of Birth:________________

Please specify what information we can or can not release:____

Please specify whom we may speak to regarding your financial account:______________________________________

______ Please do not release any of my medical information to anyone other than myself.

_______ I give you permission to make reminder calls to:

_____ Home

_______ Answering Machine/Voice Mail

_____ Work

_______ Do Not leave a Message

______ Cell

_______ Specify Person____________________

_________(initial) I understand that after 3 missed appointments that I will be discharged from the practice.

Signature:____ Date:_________________________

Witness:____ Date:_____________________________

*******If at any time you wish to change this information or update it please inform the front desk staff***********