FLORIDA UROGYNECOLOGY
AND
RECONSTRUCTIVE PELVIC SURGERY,PA

PATIENT INFORMATION RELEASE AND AUTHORIZATION FOR USE OF ANSWERING MACHINES and EMAIL

I, _____ (name of patient), authorize "Florida Urogynecology & Reconstructive Pelvic Surgery, P.A." to provide detailed information to me via my home and/or work answering machine, cell phone voice mail, and/or email concerning appointment, referral and test information. I understand that information left on an answering machine could be overheard by others. Please leave messages for me on the telephone number designated below. I understand that I may revoke this authorization at any time.

I release Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. from any and all legal liability that may arise from leaving this information on my answering machine.

_____ _____

Patient Signature **Designated phone number**

_____

Date

I give my permission for Florida Urogynecology & Reconstructive Pelvic Surgery to release information regarding my medical condition to the following:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient's Signature **Date**