HAHN Ob-Gyn Associates

Obstetrics & Gynecology

Dr. Yoram Hahn, M.D., FACOG
Dr. Eran M. Hahn, M.D., FACOG
Dr. Shannon J. Potter, M.D., FACOG

3466 McKelvey Rd.
Bridgeton, MO 63044

1035 Bellevue Ave., Ste. 105
St. Louis, MO 63117

Tel.: (314) 344-8100
Fax: (314) 344-8102

In order to make communications concerning appointments and treatment easier, the law requires your consent to release medical information. Please list specific names of family members and/or friends that have permission to obtain information from this office regarding your diagnosis and medical care.

Name/Relationship ______________________________

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I do give permission for you to leave a message on my:

Home answering machine ______________________________
Work voice mail ______________________________
Cell phone ______________________________

Patient name ______________________________

Signature ______________________________

Date ______________________________

Signature of patient representative if patient is a minor or an adult who is unable to sign form

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Relationship of patient representative to patient revised 05/08