Genis
Women's Care, P.C.

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Consent of a Patient to Release Medical Information to Another Individual

Patient Name:_____ Date of Birth:_____

I hereby authorize Genis Women's Care, PC to release my medical information to:

Name:_____ Relationship:_____
Address:_____ City: _____ State:___ Zip:_____
Phone: _____

For Minors: I understand that under Virginia Law, as a "minor" I am deemed an adult and can consent to my own treatment withouth the consent or notification of parent or legal guardian for the purpose of:

1. **Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease with the State Board of Health requires to be reported;**
2. **Medical or health services required in case of birth control, pregnancy or family planning except fot the purpose of sexual sterilizatiom**
3. **Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse;**
4. **Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance.**

All Patients: Not withstanding my ability to consent to my own treatment for the above purposes, I want my parent/legal guardian/other who is named above to have access to my medical information and be consulted regarding my treatment. This authorization includes full disclosure of all records including: clinical findings, diagnosis, treatment, assessment, recommendations for future dates of hospitalizations/ambulatory visits, charges, drug/alcohol use, psychiatric condition and sexually transmitted diseases.

You have the right to make exclusions to the information you want released by listing any such exclusions below.

Exclusions: _____

Patient Signature: _____ Date: _____