Greater Washington Maternal Fetal Medicine & Genetics

HIPAA Consent Form

Consent to Leave Messages

I _____, DOB _____, authorize Greater Washington Maternal-Fetal Medicine & Genetics to:

☐ Leave a message at the following number: _____

☐ Do not leave message:

_____ _____

Print Name Signature Date

Release Of Medical Information

(Optional)I _____, DOB _____, authorize Greater Washington Maternal-Fetal Medicine and Genetics to discuss all information regarding my care during my current pregnancy with: (You do not need to list your Obstetrician; all records will go to the doctor that referred you to our practice.)

- Name: _____
  Relationship: _____
  Address: _____
  _____
  Phone Number: _____

- Name: _____
  Relationship: _____
  Address: _____
  _____
  Phone Number: _____

_____ _____

Print Name Signature Date