

*The Center for Breast Health* 

I \_\_\_\_\_ give permission for the following people to receive information about my health account.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

I do/Do not (circle one) give permission to leave messages on a answering machine and/or voice mail on cell phone.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_