



COPPERSTATE
OB/GYN
 ASSOCIATES LTD.

Women's Health Specialists

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INFORMATION RELEASE AUTHORIZATION

I, _____ (patient name) authorize Copperstate to release the following information: (please check)

- Appointment times
- Test results
- Financial/Insurance information
- All information

To the following family member(s) or friend(s) if requested:

I Do Not want information shared with anyone.

 Patient Signature

 Date

 Witness

 Date

A Legacy of Caring