



CHRISTINE EDWARDS, MD FACOG
LAURA WALSH LAFFINEUSE MD FACOG

MEDICAL INFORMATION RELEASE

I, _____ agree to the doctors discussing my information/giving results of tests to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

CONSENT FOR EMAIL COMMUNICATION

Email messaging allows Florida Perinatal Center's health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email messaging is not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage during transmission.

If you would like to exchange email messages that contain your health information, please complete and sign this Consent below. You are not required to authorize the use of email messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of your email, we will continue to use telephone, fax or US mail to communicate with you.

Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Email: _____