

DR. POPPY DANIELS, MD

NATURAL HORMONE REPLACEMENT SPECIALIST
AND GENERAL GYNECOLOGIST

I understand that no personal medical information shall be released to anyone. However, I am giving my permission to Dr. Poppy Daniels, MD to discuss my personal medical information to the following as listed below:

Name:	Relationship:	Phone Number:

Furthermore, I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____