A Woman's View Women's Healthcare

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AUTHORIZATION FOR THE USE OF RELEASE OF PROTECTED HEALTH INFORMATION

_____ _____
Name of Patient (please print) Date of Birth

_____ _____
Street Address City State Zip Phone Number

_____ _____
Maiden Name (or other names used) Social Security Number

I authorize the following individual or organization to disclose the above named individual's health information:

Dr. / Hospital Name _____ Address _____

Phone Number _____ Fax Number _____

This information may be disclosed to and used by the following individual or organization:
Dr. / Hospital Name: **A Woman's View Women's Healthcare** Address: **2301 S. Hampton Rd., Suite 200 Dallas TX 75224**
Phone Number: **214- 339-5336** Fax Number: **214-339-5362**

For the purpose of: _____

Please release the following information from my records:

□ Complete Health Records □ History and Physical □ Ultrasound Reports
□ Operative Reports □ Laboratory Report □ other (please specify)
□ Progress Notes □ Discharge Summary

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

□ Yes, I consent to the release of this information. □ No, I do not consent the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization.

I understand that the authorization me disclosure of this health information is voluntary. I can refuse to sign this authorization. If I have questions about this disclosure of my health information, I can contact Phases of Life Women's Healthcare at **214-339-5336**.

_____ _____
Signature of Patient of Legal Representative Date

_____ _____
Relationship to Patient Witness