Southwest Women's Health, P.A.

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Authorization of Release of Information

Please print name and fill out form completely; incomplete forms are invalid and will not be processed.

Patient's Printed Name: ______________________________
(Last) (First) (M. I.)

Maiden Name or Hyphenated Name: ______________________ **Date of Birth**: ______________

THIS WILL AUTHORIZE MY INFORMATION FROM: ______________________________
(Doctor's Office/Hospital/Medical Facility)

Must include telephone: ______________________ Fax: ______________________
(Area Code) (Area Code)

Address: ____

City: ______________________ State: ______________ Zip: __________

TO BE DISCLOSED TO:

Southwest Women's Health, P. A.
883 Lead SE, Suite A, Albuquerque, New Mexico 87102
Phone: 505-247-8820 or Phone: 505-843-7131
Fax: 505-246-9421

Appointment at their office on: ______________________________
(Date of Appointment with Provider's Name)

All Gynecology Records: ☐ Labs Only: ☐ Other: ______________________

- I understand that I may revoke this request with five days by written notice. ______ **(Initials)**
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law or state law. ______ **(Initials)**
- Southwest Women's Health, P.A. will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure ______ **(Initials)**
- This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations in the following manner: Continuation of care. ______ **(Initials)**

This authorization will be in effect from: ______________________ to: ______________________
(Month/Day/Year) (Month/Day/Year)

Please allow five to ten working days to process your request.

Signature: ____
(Patient or Parent/Legal Guardian) **(Date)**

February 11, 2011