**(THIS FORM FOR RELEASE OF RECORDS ONLY)**

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize **Comprehensive Women’s Healthcare, P.A**. to request certain protected health information (PHI) about me from the party, or parties, listed below. This authorization permits Comprehensive Women’s Healthcare, P.A. to request my PHI from:

(Please provide complete name, address, phone & fax number of doctor or clinic)

The following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc)

This authorization will expire one year from today, unless otherwise specified.

I have the wright to revoke this authorization in writing except to the extent that Comprehensive Women’s Healthcare, P.A. has acted in reliance upon this authorization. My written revocation must be submitted to **Comprehensive Women’s Healthcare, P.A.**’s privacy officer at 1054 Texas Trail, Suite 100, Grapevine, Texas 76051.

Signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of patient/legal guardian Relationship to patient

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 Print Patient’s name Date

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 Social Security Number of Patient