

Southwest Women's Care, PC  
16611 South 40th Street, Suite 180  
Phoenix, AZ 85048  
(480) 785-2100 Phone  
(480) 785-2111 Fax

*For Medical Records Use Only*

Total Paid \_\_\_\_\_ Appointment Date \_\_\_\_\_  
Date \_\_\_\_\_ Initials \_\_\_\_\_  
To be picked up \_\_\_\_\_  
Date Faxed \_\_\_\_\_ Date Mailed \_\_\_\_\_

**PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION**

\_\_\_\_\_  
Name of Patient (Please Print) Date of Birth

\_\_\_\_\_  
Street Address City State Zip Phone

\_\_\_\_\_  
Maiden Name or other names use for records Clinic Use: MRN

I hereby authorize: (Please Print) To release to: (Please Print)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The following information from my records:

- Complete Health Record(s)
- Health Records from Dr(s) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

Covering the period from \_\_\_\_\_ to \_\_\_\_\_

I understand that this will include information relating to

- Acquired Immunodeficiency syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
- Psychiatric care
- Treatment for alcohol and/or drug abuse

If any, except as specifically stated here: \_\_\_\_\_

This information is to be disclosed for the purpose(s) of \_\_\_\_\_

Specify the date, extent or condition upon which this authorization expires: \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Southwest Women's Care, PC at the above address. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in sixty (60) days from the date below.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including charges for labor and supplies up to \$25.00. A copying charge of \$0.50 for the first 250 pages and \$0.35 for additional pages, and the reasonable cost of all duplication of records that cannot be routinely duplicated on a standard photocopy machine will be charged.

Southwest Women's Care, PC is not responsible for completeness, legibility, or omission caused by the copying of any medical records from another institution.

\_\_\_\_\_  
**Signature of Patient or Patient's Representative** **Date**

Printed Name of Patient's Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_