

*Comprehensive Women's Healthcare, P.A.*  
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**(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 use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits **Comprehensive Women's Healthcare, P.A.**, to use or disclose to:

\_\_\_\_\_

(Please give complete name, address and fax number of doctor/clinic)  
**(A personal copy of records for patients requires a \$25 prepayment)**

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 on \_\_\_\_\_.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right 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 1600 W. College Street, Suite 1101, Grapevine, Texas 76051.

Signed by: \_\_\_\_\_  
Signature of Patient/Legal Guardian      Relationship to patient

\_\_\_\_\_  
Patient's Name      Date

\_\_\_\_\_  
Social Security Number of Patient