Comprehensive Women's Healthcare
1760 E. Pecos Road, Ste. 207
Gilbert, AZ 85295
Phone: (480) 813-0944
Fax: (480) 813-0038

Medical Information Authorization

Patient Name: _____

DOB: _____

I understand that my information will only be shared with those involved with the maintenance of my care and individuals that I provide the office permission to speak with regarding results or my medical information. Please list all names and phone numbers of individuals you allow our office to release information to if needed:

Name: _____Relationship:_____Phone Number:_____

Name: _____Relationship:_____Phone Number:_____

Name: _____Relationship:_____Phone Number:_____

This authorization is valid from_____ to _____
(Start Date) (End Date)

☐ I decline to list any authorized individuals to receive information about my care/results.

Please indicate which information can be disclosed:

☐ Pap Smear Reports
☐ Pathology Reports
☐ Medication Log
☐ Progress Notes
☐ Operative Reports
☐ Pre-Natal Records
☐ Labs/X-Ray/Ultrasound Reports
☐ HIV
☐ H&P
☐ Discharge Summary
☐ **ALL RECORDS**
☐ Other: _____

_____ _____
Patient Signature Date

_____ _____
Comprehensive Women's Healthcare Staff Witness Date