

**Authorization for CWH to Obtain Protected Health Information (PHI)**

I hereby authorize **Comprehensive Women's Health** to obtain the following medical records needed for my care:

- Progress Notes
- Lab Results
- Test Results
- X Rays
- Correspondence
- Other \_\_\_\_\_

From the following physician or group practice:

Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone number: \_\_\_\_\_  
 Fax number: \_\_\_\_\_

Please forward all records to:  
 Comprehensive Women's Health  
 10313 Georgia Avenue, Suite 307  
 Silver Spring, MD 20902  
 Phone: 301-754-2222  
 Fax: 301-754-2011

Print Patient Name:

Date of Birth:

Patient Signature:

Today's Date:

**WARNING:** The information contained in this facsimile and any documentation attached is confidential and legally privileged. It is solely intended for the addressee. Access to the information by anyone else is unauthorized. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution, or duplication of this information may be unlawful.