



COMPREHENSIVE
WOMEN'S HEALTH

Records Release Form

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: _____

Please forward all records to:
Comprehensive Women's Health
2101 Medical Park Drive, Suite 300E
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.