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
10313 Georgia Ave, STE 307,
Silver Spring, MD 20902
Phone: 301-754-2222
Fax: 301-754-2011

Print Patient Name:	Date of Birth:
Patient Signature:	Today's Date: