



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:

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