

*Comprehensive Women's Healthcare, P.A.*  
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**PATIENT AUTHORIZATION FOR PRACTICE TO REQUEST PROTECTED HEALTH INFORMATION FROM THIRD PARTIES**

By signing this authorization, I authorize **Comprehensive Women's Healthcare, P.A.**, to request certain protected health information (PHI) about me from the party or parties listed below. This authorization permits **Comprehensive Women's Healthcare, P.A.**, to request my PHI from:

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(Please give complete name, address and fax number)

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc).

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This authorization will expire on \_\_\_\_\_.

I have the right to revoke this authorization in writing except to the extent that **Comprehensive Women's Healthcare, P.A.** has acted in reliance upon this authorization. My revocation must be submitted to **Comprehensive Women's Healthcare, P.A.**'s Privacy Officer at 1600 W. College Street, Suite 1101, Grapevine, Texas 76051.

Signed by: \_\_\_\_\_  
Signature of Patient/Legal Guardian      Relationship to patient

\_\_\_\_\_  
Patient's Name      Date