Revised 12-27-19

Southwest Women's Health Associates

1305 Escalante Drive Suite 201
Durango, CO 81303
Phone: (970) 247-0042

Send Records To: _____

Address: _____

Phone Number:_____-_____ **Fax Number:** _____-_____

_____

This authorization permits Southwest Women's Health Associates to disclose to _____ the following individually identifiable health information.

_____ **All Medical Records**

_____ **Most recent annual exam report and findings**

_____ **Lab Reports (specify if possible)** _____

_____ **Alcohol and drug dependency information**

_____ **HIV results/information**

_____ **Other (please specify):** _____

*Copying records for a provider, to whom SWHA refers you, is a courtesy provided by Southwest Women's Health at no charge. We reserve the right to charge the patient a labor, postage and supply fee of $10.00-$20.00 for records copied for any other reason. Thank You.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Southwest Women's Health Assoc. has acted in reliance upon this authorization.

Signature of patient:_____ **DOB:**_____

Printed name: _____ **DATE:** _____

Witness to signature: _____ **DATE:**_____

Authorization will expire on: _____