1305 Escalante Drive Suite 201
Durango, CO 81303
Phone: (970) 247-0042
Fax: 970-259-8837

Name of office Releasing Records: _____

Address of office Releasing Records: _____

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

_____

This authorization permits _____to disclose to **Southwest Women's Health Associates** 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):** _____

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 if ever need be.

Send records to:

Southwest Women's Health Associates
1305 Escalante Drive Suite 201
Durango, CO. 81303

Signature of patient:_____ DOB:_____

Printed name: _____ DATE: _____

Witness to signature: _____ DATE:_____

Authorization will expire on: _____

Revised 03-08-2023