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

Send Records To: _____

Address: _____

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.

*Copying records for a provider, to whom Southwest Women's Health refers you is a courtesy provided by our office at no charge. We reserve the right to charge the patient a labor and supply fee of .20 cents per page and actual shipping cost for records copied for any other reason.

Signature of patient:_____ DOB:_____

Printed name: _____ DATE: _____

Witness to signature: _____ DATE:_____

Authorization will expire on: _____

Revised 03-08-2023