Trilogy Women's Health, P.A.
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PATIENT AUTHORIZATION FOR PRACTICE TO REQUEST PROTECTED HEALTH INFORMATION FROM THIRD PARTIES

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

_____

_____
(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.)

_____

_____

_____

This authorization will expire on _____.

I have the right to revoke this authorization in writing except to the extent that **Trilogy Women's Health, P.A**. has acted in reliance upon this authorization. My revocation must be submitted to **Trilogy Women's Health, P.A.'s** Privacy Officer at 1631 Lancaster Drive, Suite 220, Grapevine, Texas 76051.

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

_____ _____
Patient's Name Date