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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

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

_____

_____
(Please give complete name, address and fax number of doctor/clinic)
(A personal copy of records for patients requires a $25 prepayment)

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 _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may be protected by the federal HIPPA Privacy Rule. 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 written 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

_____
Social Security Number of Patient