Park West Women's Associates, PLLC

Daisy A. Ayim, M.D., F.A.C.O.G
12606 West Houston Center Blvd., Suite 120 Houston, TX 77082
Phone: 713-640-5922 Fax: 713-640-5982

Authorization for Use or Disclosure of Protected Healthcare Information

I, _____, hereby authorize _____: to (check those that apply):

_____ use the following protected health information; and/or

_____ disclose the following protected health information to: Park West Women's Associates, PLLC

- ☐ All healthcare information
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Other: _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis,drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

This protected health information is being used or disclosed for the following purposes:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Daisy A. Ayim, M.D. at 12606 West Houston Center Blvd., Houston, TX 77082.

I understand that I have the right to:

! Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)

! Refuse to sign this authorization.

_____ _____
Signature of Patient or Patient Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

THIS AUTHORIZATION EXPIRES 120 DAYS AFTER IT IS SIGNED.