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

Patient Name_____DOB_____

May ***Park West Women's Associates*****,** and/or members of the office staff release medical information to specified persons other than you or your PCP? Yes___ No___

If yes, please specify to whom this information may be released.

Authorized Person	**Relationship to You**
_____	_____
_____	_____
_____	_____

What information may be released?

Lab results	Yes___	No ____
X-ray reports	Yes___	No ____
Medications	Yes___	No ____
Medical status	Yes___	No ____
Appointments	Yes ___	No ____

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnoses and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical record, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me on request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

_____ _____
Patient Signature Date