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PROGRESSIVE WOMENS HEALTH, PLLC
ASIA MOHSIN, MD

AUTHORIZATION FOR RELEASE OF TEST RESULTS

Last Name: _____ First Name: _____ Date of Birth: _____

I, undersigned, hereby consent to, and authorize at Progressive Womens Health (PWH), PLLC to send my results by:

- ☐ Email (please indicate): _____
- ☐ Fax (please indicate): _____
- ☐ Pick up at the office by an authorized person (please indicate):
  1) _____
  2) _____
  3) _____

We will no longer go over test results over the phone due to high call volume and the inability to explain the results over the phone. If you would like to discuss your test results, please make an appointment with the front office.

I acknowledge that I have read this authorization for release of test results in its entirety.

Patient/Guardian's Name: _____

Patient/Guardian's Signature: _____

Date: _____