Associated Women's Care Physicians, P.C.

EXHIBIT A

Authorization to Disclose Protected Health Information

I authorize Associated Women's Care Physicians, P.C. to disclose Protected Health Information described below:

(Please check one)

[ ] Laura B. Doan, MD/University Health Women's Care/3450 NE Ralph Powell Rd., Lee's Summit, MO 64064

[ ] Ingenue F. Cobbinah, MD, Rocco Florio, DO, Rachel Jones, WHNP, Kelli Knapp, WHNP/Saint Luke's Women's Health East-2741 NE McBaine Dr., Lee's Summit, MO 64064

[ ] Anna Soendker, MD/Healthcare for Women/19550 E. 39th St., Suite 310, Independence, MO 64057

[ ] Self-The best phone # to reach me when disk is ready for pickup: _____

1. Due to the dissolution of the Practice, I understand my entire medical record will be included.
2. The reason for releasing my medical records is the Dissolution of the Practice.
3. This Authorization shall be in force immediately and permanently.
4. I understand that I have the right to revoke this Authorization at any time by submitting a written request to Associated Women's Care Physicians, P.C., except to the extent that action has been taken in reliance on it.
5. I understand that my treatment will not be conditioned on whether I sign this Authorization.
6. I understand that information disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
7. I further understand that Associated Women's Care Physicians, P.C. will provide my medical records on a disk at no charge if my release form is requested by March 1st, 2017. After March 1st, there will be a minimum $ 25 fee for medical records. ***Due to the high volume of requests, Associated Women's Care is unable to provide paper copies of records. All records will be provided via disk and will need to be picked up. We are unable to mail any disks.***

You can mail or email your request:
Mail: 923 NE Woods Chapel Rd., PMB #338, Lee's Summit, MO 64064
Email: info@awcpobgyn.com

_____ _____/_____/_____
Signature of Patient or Personal Representative Date

_____ _____/_____/_____ _____
Print Name of Patient or Personal Representative Patient's Date of Birth Relationship to Patient

For Office Use Only: GW patient id# _____ Disk Created _____/_____/_____ Initials _____