



Obstetrics & Gynecology

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Gilbert, AZ 85297

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Gilbert, AZ 85234

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records between

Valley Women For Women, PC
Attn: Medical Records
3815 S Val Vista Drive, Ste 101
Gilbert, AZ 85297
FAX 855-329-8939
Email: records@vwfw.com

and (name and address of health care provider):

Name
Address
Phone Fax

I am releasing records (check only one)
[ ] TO Valley Women for Women, PC.
[ ] FROM Valley Women for Women, PC.

Place a check mark below to indicate the records you wish to release:

[ ] All Records [ ] Lab Reports [ ] Pap [ ] Ultrasounds
[ ] Doctors' Notes [ ] Other

Reason for release (please be as specific as possible):

Reason for release text input area

I understand that I may revoke this consent at any time and that, upon fulfillment of the above stated purpose this consent will expire one year following the date of signature.

Patient Name: D.O.B.
Signature: Date