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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This release authorizes: (Name/Address of Health Care Provider)

to release to Valley Women For Women the information specified below from the medical records maintained when I was treated in the above facility

_____ Doctors' Notes

_____ Lab Reports

_____ Ultrasounds

_____ Pap

_____ Other

Send or fax medical records to:

Valley Women For Women, PC
Attn: Medical Records
3815 S Val Vista Drive, Ste 101
Gilbert, AZ 85297
FAX 480-782-1330

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

Patient Name: _____ D.O.B. ____/____/____

Signature: _____ Date _____

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