

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 855-329-8939

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 _____

Warning: This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that dissemination, distribution or copying of this information is strictly forbidden. If you have received this message in error, please notify us immediately and destroy this message.