Authorization to Release/Obtain Medical Records

Patient Name: _____Date of Birth_____

Today's Date: _____ Phone: _____

Records Released From:

Name:_____

Address:_____

City, State, Zip:_____

Phone: _____ Fax: _____

Records Released To:

Name:_____

Address:_____

City,State,Zip:_____

Phone: _____ Fax: _____

Information to be Released/Obtained:

☐ Complete Medical Records ☐ Labs ☐ Billing Records ☐ Records Related to:

_____

Purpose of Disclosure:

☐ Transfer of Care ☐ Personal Use ☐ Legal or Insurance Review ☐ Continuation of Care

☐ I release North Scottsdale Women's Health, your physicians, and employees from liability for following this authorization and request. ***I understand it may take up to 15 business days for completion of this transaction.*** I understand I will ONLY be given copies of records created or ordered by this office. **I understand that if records are requested to be sent to anyone other than another physician's office there is a fee of $35.00.**

☐ I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

☐ I understand I have the right to revoke this authorization, in writing, at any time. The revocation will not apply to information that has already been released as a result of this authorization. Unless otherwise revoked, this authorization will expire one (1) year from the signing date.

Patient's Named (printed):_____

Legal Gaurdian/Personal Representative (if applicable): _____

Signature:_____**Date:**_____