DESERT WEST
OBSTETRICS & GYNECOLOGY, LTD.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
DISABILITY/FMLA FORMS

Records coming from: Desert West OB/GYN
5601 W Eugie Ave #100
Glendale, AZ 85304
Phone 602-978-1500 Fax 602-978-1575

Records going to: Name: _____
(**Disability**) Address: _____
⬭ Mail City:_____State:_____Zip: _____
⬭ Fax Phone:_____Fax: _____

Records going to: Name: _____
(**FMLA**) Address: _____
⬭ Mail City:_____State:_____Zip: _____
⬭ Fax Phone:_____Fax: _____

I authorize the release of record(s), including those that may contain confidential HIV/AIDS related information, confidential communicable disease related information and information relating to mental health and alcohol/ drug use. Please release this information to my employer or Disability Company as marked above. This consent shall expire automatically six (6) months from the date on which it was signed.

Print Patient Name_____Date of Birth_____

Signature of Patient/Authorized Person_____

Print Name _____ Date _____

Relationship to Patient_____Witness_____

Please Note: There is a $25 charge per form. This fee is payable prior to completion. Please allow 5-7 business days for completion.

Pmt: _____Cash _____CC _____Ck#_____ _____Emp. Initials