DESERT WEST
OBSTETRICS & GYNECOLOGY, LTD.

5601 W. Eugie Ave., Ste. 100 Glendale, AZ 85304 602-978-1500 ext.4869 Fax 602-978-0409

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records coming from: Name_____
Address_____
City_____ State_____ Zip_____
Phone_____ Fax_____

Records going to: Name_____
Address_____
City_____ State_____ Zip_____
Phone_____ Fax_____

_____Mail _____Fax _____Pick Up

I authorize the release of records, including those that may contain confidential HIV/AIDS related information, confidential communicable disease related information and information relating to mental health and/or alcohol/drug use. Please release the following records:

_____ Prenatal/Obstetrical Records Date of Service_____

_____ Lab Report Date of Service_____

_____ Operative/Pathology Report Date of Service_____

_____Gynecological Record Date of Service_____

_____Other (please specify)_____ Date of Service_____

_____Complete record

Reason for request_____

Patient Name_____

Date of Birth_____ Social Security number_____

_____ _____
Signature of Patient Date

Signature of Other Authorized Person_____

Print Name_____ **Relationship to Patient**_____

Witness_____

*This consent shall expire automatically six (6) months from the date on which it was signed.

3/08