6678 W. Thunderbird Road Glendale, AZ 85306 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 of Patient_____

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