



DESERT WEST
OBSTETRICS & GYNECOLOGY, LTD.

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: _____

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/ Radiology 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 and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.***

_____***I understand there is a \$35 fee for copies of medical records for personal use. (please initial)***

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