Medical Records Authorization Release

Scottsdale Personal OBGYN

8414 E Shea Blvd Suite 103

Scottsdale, AZ 85260

Office 480-794-1000 Fax 480-860-2433

Patient Name: _____

Date of Birth: _____/_____/_____

Social Security Number: _____/_____/ _____

I Authorize:

_____

_____

_____

To release my medical records to:

_____

_____

_____

Information to be released will consist of all your records, including your progress notes, radiology reports, labs, HIV, and other confidential tests.

UNLESS OTHERWISE INDICATED IN WRITING BELOW.

I may revoke this authorization at any time by providing written notice. I hereby waive all provisions of law and privileges relating to disclosures hereby authorized. I understand that there is no charge when records are mailed to a medical provider for continuing care. I also understand that there's a $25.00 fee that will be charged for the copying of any records sent to any party other than a medical provider including myself.

PLEASE ALLOW UP TO 48-72 HOURS FOR THE COMPLETION OF MEDICAL RECORDS REQUESTS.

X_____ Date: _____