Request or Release of Medical Records

I hereby authorize the use or disclosure of my identifiable health information (medical records and test results, including AIDS and/or HIV testing and results, sexually transmitted diseases, and alcohol, drug and psychiatric treatment.) as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider; the released information may no longer be protected by federal privacy regulations.

Information to be released:

□ **To:**
□ **From:**

North Scottsdale Women's Health
9745 North 90th Place
Scottsdale, AZ 85258

Phone: 480-661-1485
Fax: 480-661-1495

□ **To:**
□ **From:**

Name/Medical Facility _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax:_____

Complete records_____ **Specific Dates** _____ **Other** _____

Please specifically include:

_____
_____

Purpose of disclosure:

__ Personal Use
__ Transfer of GYN Care
__ Transfer of Obstetrical care
__ Legal or Insurance Review
__Continuation of Care

I release you, your physicians, and employees from liability for following this authorization and request***. I understand it may take up to 15 business days for completion of this transaction***. I understand I will ONLY be given copies of records created or ordered by this office. If you need records from other physicians, offices, or laboratories, please contact those offices for copies.

I understand that it if records are requested to be sent to anyone other than another physician's office, there is a fee of $35.

Patient's Name (printed) _____Date of Birth_____

Patient's Name (signature) _____Today's Date_____