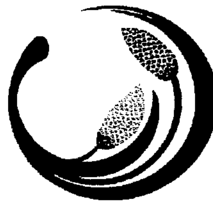

DESERT WEST
OBSTETRICS & GYNECOLOGY, LTD.

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