AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient's Name: _____Date of Birth: _____

Address: _____Home Phone:_____

_____ Other Phone: _____

_____ Email: _____

REQUESTING RECORDS FROM: _____

ADDRESS: _____

PHONE: _____

MAIL OR FAX RECORDS TO:

Oasis Obstetrics & Gynecology,PLC
6239 E. Brown Rd.
Suite 112
Mesa, AZ 85205

Phone: (480) 854-2676 (born)
FAX: (480) 854-3618

Please release ***all*** medical records ***unless*** specific date, procedure, or other items listed below are specified:

_____

Reason for requesting records:

_____

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I authorize the release of the above requested records, including those, which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address.

I further authorize that these medical records may be faxed if necessary.

I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

_____ _____ _____

Patient Signature (or parent/legal guardian if minor) **Relationship to Patient** **Date**