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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS / INFORMATION

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Soc Sec #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prior Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I AUTHORIZE THE FOLLOWING FACILITY/PHYSICIAN TO RELEASE MY MEDICAL RECORDS/INFORMATION:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Complete Medical Record (OR)

[ ] Medical Records for last \_\_\_\_\_\_\_\_ years

[ ] Labs from date of service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Progress Note from date of service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Operative Report from date of service \_\_\_\_\_\_\_\_\_\_\_ [ ] Pathology Report date of service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other ( Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE RELEASE MY RECORDS TO:

SHEA WOMEN’S CARE

9500 E Ironwood Square Drive, Suite 124

Scottsdale, AZ 85258

PHONE: 480-767-0010 FAX: 480-767-0030

Reason for release of medical records:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please be aware that the complete medical record includes progress notes, radiology reports, labs, HIV and other confidential tests unless otherwise indicated here in writing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that there is no charge when records are mailed to a medical provider for continuation of medical care, supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance.

Records will be processed as quickly as possible, but please allow 7-10 business days.

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Signature of patient or person legally authorized to consent on patient's behalf Date