



Andrew W. Carter MD
Brenda A. Martin MD
Sara Giali DO
Wendy Bennetch Jones MSN,WHNP-BC
9500 E Ironwood Square Drive, Suite 124
Scottsdale, AZ 85258
Telephone: (480) 767-0010 Fax: (480) 767-0030

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:

**SHEA WOMEN'S CARE
9500 E. IRONWOOD SQUARE DR, STE. 319
SCOTTSDALE, AZ 85258
PHONE: 480-767-0010 FAX: 480-767-0030**

- 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:

Phone: _____ Fax: _____

Reason for release of medical records:

- Continuation of care
- Other: _____

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.

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

Date