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9500 E. Ironwood Square Drive Suite 124
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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS / INFORMATION

Patient Name: ____

Date of Birth: ____________ 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.

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