Office Use Only
Date received: ______________________
Provider Initials: ____________________
Date Released: _______________________
Staff Initials who sent info: ____________

Today's Women's Health Specialists
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Chandler, AZ 85225
Phone: (480) 963-7900 Fax: (480) 899-8954

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Medical Records Release/Request Form

Patient Name: ____
(Last, First, Middle) (Previous Name)

Address: ____

Date of Birth: ___________ Home/Work Phones: _________________ Social Security Number: _________________

Reason for record request: ____

Release Records **From** TWHS **To:**		Release Records **To** TWHS **From:**
________________________________ (Name)		________________________________ (Name)
________________________________ (Address)	**OR**	________________________________ (Address)
________________________________ (City) (State) (Zip)		________________________________ (City) (State) (Zip)
________________________________ (Phone Number) (Fax Number)		________________________________ (Phone Number) (Fax Number)

I hereby authorize the release of photocopies of the following medical records and/or x-ray films in the possession or control of the above named medical facility, its employees and/or agents. For the purposes hereof, *"medical records"* and *"x-ray films"* shall include all confidential HIV-related information (as defined in A.R.S. Section 36-661), confidential communicable disease-related information (as defined in A.R.S. Section 36-661), confidential alcohol or drug abuse related information (as defined in 42 CFR section2.1 ET SEQ.), and confidential genetic testing and mental health diagnosis/treatment information (as defined in A.R.S. Section 12-2801).

Information to be released:

___ All Medical Records ___ OB Records Only ___ GYN Records Only

___ X-Ray Reports ___ X-Ray Films ___ Lab Reports

___ Other Records (specify) ____

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Today's Women's Health Specialists based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

This authorization expires within six (6) months from the date signed. If you wish to have the authorization expire before six (6) months, please indicate the date of expiration: ______________________.

_________________________________ _________________________________
Patient or legally authorized individual signature Date Time

_________________________________ _________________________________
Printed Name if signed on behalf of patient Relationship (parent or legal representative)

A copy of this release shall be as binding at the original