UNIVERSITY OBSTETRICS AND GYNECOLOGY

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AUTHORIZATION TO RELEASE MEDICAL RECORDS *TO* UNIVERSITY OBSTETRICS & GYNECOLOGY

4915 E. Baseline, Bldg #10, Suite 126
Gilbert, Arizona 85234
Phone 480-969-3096 Fax 480-969-0963

Patient Name:______________________________ Date of Birth:__________________

Address:__________________________________ SS#:__________________

__________________________________ Home phone:__________________

__________________________________ Work phone:__________________

I hereby authorize University OB-GYN to request photocopies of all medical records concerning the above named patient from:

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I hereby authorize hereof, "MEDICAL RECORDS" shall include all confidential HIV-related information and/or 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 section 2.1 ET SEQ) and confidential mental health diagnosis / treatment information unless otherwise indicated below.

______ Release a copy of **ALL** medical records

______ Release **ONLY** the records specified as follows:______________________________

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Patient signature:______________________________ Date:__________________

Witness signature:______________________________ Date:__________________