ESTRELLA WOMEN'S HEALTH CENTER
AOA family of obgyn physicians

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Medical Records Release/Request Form

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

Address: _____

Date of Birth: _____ Telephone #: _____ Social Security Number: _____

Reason for Record Request: _____

Release Records **FROM** Estrella Women's Health **TO:**		Release Records **TO** Estrella Women's Health **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 in the possession or control of the above named facility, its employees and/or agents. For the purposes hereof, *"medical records"* 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 section 2.1 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 __ Obstetrical Records Only __ GYN Records Only __ Radiology Reports

__ Laboratory Reports __ Operative Reports __ Pathology Reports __ Past 2 Years

__ Other Records (specify) _____

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Arizona OBGYN Affiliates (Estrella Women's Health Center branch) 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: _____.

It is further understood that there may be a fee, payable by the patient for releasing these records.

_____ _____
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 as the original.

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***Fax:* (623) 846-1674**