Valley Women for Women
Obstetrics & Gynecology
(480) 782.0993 phone
(833) 337-0386 toll free fax
www.vwfw.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records between

Valley Women For Women
Attn: Medical Records
3815 S Val Vista Drive, Ste 101
Gilbert, AZ 85297
FAX 833-337-0386
Email: records@vwfw.com

and (name and address of health care provider):

Name _____

Address _____

Phone _____ Fax _____

I am releasing records (check only one) ☐ **TO** Valley Women for Women

☐ **FROM** Valley Women for Women

Place a check mark below to indicate the records you wish to release:

☐ All Records ☐ Lab Reports ☐ Pap ☐ Ultrasounds

☐ Doctors' Notes ☐ Other _____

Reason for release (please be as specific as possible):

_____

_____

_____

I understand that I may revoke this consent at any time and that, upon fulfillment of the above stated purpose this consent will expire one year following the date of signature.

Patient Name _____ Date of Birth _____

Signed _____ Dated _____