

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	
	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 Repor	ts \square Pap \square Ultrasounds
□ Doctors' Notes □ Other	
Reason for release (please be as specific as possible):	
I understand that I may revoke this consent at consent will expire one year following the date	any time and that, upon fulfillment of the above stated purpose this of signature.
Patient Name	Date of Birth
Signed	Dated

Warning: This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that dissemination, distribution or copying of this information is strictly forbidden. If you have received this message in error, please notify us immediately and destroy this message.