



W·R·E·N Obstetrics, Midwifery, & Gynecology

Women's Health *Arizona*

**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** WREN Obstetrics, Midwifery and Gynecology Mercy Rd **TO:** \_\_\_\_\_ Release Records **TO** WREN Obstetrics, Midwifery and Gynecology Mercy Rd **FROM:** \_\_\_\_\_

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Name)

**OR**

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(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 WREN Obstetrics, Midwifery and Gynecology Mercy Rd 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.*