

# Medical Records Release

North Scottsdale Women's Health  
9745 N 90<sup>th</sup> Place Scottsdale, AZ 85258  
Ph. 480-661-1485 Fax 480-661-1495

I authorize North Scottsdale Women's Health to release my medical records to:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

For the following reasons: \_\_\_\_\_

continue care  personal use  2<sup>nd</sup> opinion  transfer care  insurance request

Release the following information:  complete records  labs/mammo/pap  recent visit  
 Prenatal/OB records  other \_\_\_\_\_

I understand that the information disclosed may contain personal information that is protected by Federal and State laws including information that might relate to alcohol, drug, and psychiatric treatment, AIDS and /or HIV testing, or sexually transmitted diseases. My signature gives specific consent to release and disclose this information.

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

Previous name (if any) \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

\*If records are released directly to another Physician there will be no charge. If records are requested for personal or insurance use a \$35.00 fee maybe required.