

# Release of Medical Records

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Records to be released **TO: North Scottsdale Women's Health**  
**9745 N 90<sup>th</sup> Place Scottsdale, AZ 85258**  
**Ph. 480-661-1485 Fax 480-661-1495**

Records released **FROM :** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Release the following information:

complete medical records                       labs/radiology/mammo/us report  
 recent visit notes                                       other: \_\_\_\_\_

I hereby authorize the release of my complete medical records to the above physician/practitioner. I understand that the information disclosed may contain personal information that is protected by Federal and State laws including information which may relate to alcohol, drug, and psychiatric treatment. AIDS/HIV testing, or sexually transmitted diseases. My signature gives consent to release this information.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_