Desert Jewel Wellness & Gynecology

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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____

Prior Name (if seen under another name): _____

Date of Birth:_____ Social Security Number: _____

I AUTHORIZE:

_____

Phone Number: _____ Fax Number: _____

TO RELEASE THE FOLLOWING MEDICAL RECORDS:
Medical Records for the last _____ years
Labs from date of service of _____
Other _____

RECORDS ARE TO BE SENT TO:

_____

Phone Number: _____ Fax Number: _____

Information to be released is to consist of all records, including progress notes, radiology reports, labs, HIV and other confidential tests **unless otherwise indicated here** in writing: _____
I may revoke this authorization at any time by providing written notice of revocation. However, I may not revoke the authorization retroactively for information already released. I hereby waive all provisions of law and privilege relating to disclosures hereby authorized. I understand that there is no charge when records are mailed to a medical provider for continued care. I also understand that there is a charge when medical records are mailed to any party other than a medical provider, with the exception of the patient's first copy.

X_____
(Signature of Patient) (Date)