AZ UROGYNECOLOGY
& PELVIC HEALTH CENTER
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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____ Home Ph: _____

State Zip: _____ Other Ph: _____

MAIL OR FAX THE RECORDS TO THE ADDRESS/NUMBER ABOVE TO THE ATTENTION OF: *KRISETTE*

REQUESTING RECORDS FROM: _____

_____

_____

ph &/or fax: _____

PLEASE RELEASE MEDICAL RECORDS PERTAINING TO THE PATIENTS BLADDER AND/OR PELVIC FLOOR INCLUDING BUT NOT LIMITED TO ANY TESTING, SURGERIES AND TREATMENTS OR THERAPIES.

SPECIFIC REQUESTS: _____

Reason for requesting records: CONTINUED CARE SURGICAL CONSULT
(Circle One)
TESTING OTHER: _____

By signing this, I authorize the release of the above requested records and anything pertinent the physician feels will be beneficial in the pursuance of my over all healthcare. Including but not limited to any disclosure that may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and alcohol use, sexual history and that the records will be forwarded to the address/ph on the letterhead. I further authorize that these records may be faxed if necessary.

I understand that I may revoke this authorization at anytime, except to the extent that action based on this authorization has already taken place. I hereby give my consent freely, voluntarily and without coercion or hesitation:

_____ _____
(Patient signature or parent/legal guardian if minor) (Date)

This fax is personal and privileged information intended for the named recipient only. If you have received it in error, please destroy it and call us to let us know you have received it. Thank You.