Phone: (480) 505-4258 **Southwest Contemporary Women's Care** **Fax: (480) 505-3688**

Records Release

Name of Patient				Date of Birth
Street Address	City	State	Zip	Phone
Maiden Name or other names used for records				Clinic Use: MRN

Organization RELEASING Information (From):

Name of Physician or Company:				Attn:
Address:				Fax:
City:	State:	Zip:		Phone:

Organization or Individual RECEIVING Information (To):

Name / Facility: Southwest Contemporary Women's Care				Attn: Medical Records
Address: 2545 West Frye Road, Ste #9				Fax: (480) 505-3688
City: Chandler	State: AZ	Zip:	85224	Phone: (480) 505-4258

Medical records shall include all confidential Aids, Communicable Disease, HIV-related, Alcohol or Drug related and mental health diagnosis/treatment information. Please be advised SWCWC **cannot** and **does not** certify records provided to us from providers, other than those within our practice, are complete. We cannot guarantee we received the entire contents from the patient's current or previous physicians/practitioners or from the patient.

PLEASE DO NOT SEND RECORDS ON A CD

Release the following medical records. **There is a $15.00 charge for 15 or more pages.**

☐ Specific Records Requested: _____

☐ Labs ☐ Pap Smears ☐ Pathology ☐ Surgery Report ☐ Ultrasound ☐ Mammography ☐ DEXA

Dated From:_____ To:_____

Reason for Release

☐ Moving ☐ New Insurance ☐ Changing Doctor ☐ Consult/2nd Opinion ☐ Pregnancy Transfer of Care

☐ Other, please explain:_____

This consent will expire sixty (60) days after the date signed below. I may revoke this authorization at any time providing I notify Southwest Contemporary Women's Care, in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I hereby release SOUTHWEST CONTEMPORARY WOMEN'S CARE FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.

Signature of Patient or Patient's Legal Representative Date

_____

Relationship to Patient