Premier Care for Women

14239 West Bell Road, #210 * Surprise, Arizona 85374
(623) 584-0800 Office * (623) 584-0312 Fax * www.premiercare4womenaz.com

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Outside Medical Records Release Authorization

(Requesting your records from another provider)

I, _____ hereby authorize

_____
Patient or legally authorized person
Physician/Group

_____
Address Phone/Fax

To release the following information on:

Patient Name: _____ Birth date: _____

Patient Address:

_____

Phone Number: _____

Please check all information to be released: (Allow minimum of 3 business days for copying)

† Entire record set † Problem list † Registration record

† Medication list † Laboratory reports † Physician notes

† Imaging reports (ultrasound/mammogram)

† Other _____

Dates of treatment:

_____

Information shall be released (sent) to: Premier Care for Women
14239 West Bell Rd #210
Surprise, Arizona 85374
(623) 584-0800 * (623) 584-0312 Fax

1) I understand that my record may include reference to sexually transmitted disease, alcohol or drug use and/or AIDS or HIV status, if applicable. It may also include information about behavioral or mental health status.

† Include these records † Do not include these records

2) I understand that I may revoke this authorization at any time in writing, otherwise this consent will be considered valid for sixty (60) days.

I authorize the following individuals to pick up my records:

_____

Must bring picture ID

Authorized signature: _____ **Date:** _____

Relationship to patient: † Patient † Legal guardian † Healthcare power of attorney

(Submit signed copy)