COMPREHENSIVE WOMEN'S HEALTHCARE

1760 E. Pecos Road, Ste. 207, Gilbert, AZ 85295
Phone: 480-813-0944, Fax: 480-813-0038

MEDICAL RECORDS RELEASE FORM

Patient Information

Name: _____ DOB: _____

Address: _____

City:_____ State:_____ Zip:_____ Phone:_____

Provider (Circle One):

Eric Hazelrigg, MD Susan Kudlinski, MD Sheetal Kale, MD Craig Mechelke, DO
Cyndy Churgin, RNP-C Carla Scalmato, FNP-C Vanessa Mitchell, PA-C

Release Information

Please check the appropriate box:

☐ I authorize Comprehensive Women's Healthcare to release photocopies of my medical records to the recipient listed below.

☐ I authorize the provider listed below to release photocopies of my medical records to Comprehensive Women's Healthcare.

PLEASE NOTE: THIS REQUEST WILL BE PROCESSED WITHIN 7 BUSINESS DAYS

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

Fax: _____

Specify Records: PLEASE CIRCLE ALL TYPES TO BE RELEASED

Medical records shall include all confidential AIDS/HIV, alcohol, drug, and mental health related information, unless otherwise specified.

All Records	Operative Reports	Ultrasounds
Lab/Pathology Reports	Pre/Post Natal Records	Mammograms
Pap Smears	Progress Notes	Other:_____

Please circle reason for request:

Moving Transferring Care Patient's Request Continuation of Care Other:_____

This authorization shall become effective immediately and shall remain in effect for one year from date of signature unless a different date is specified here_____. **Personal requests for duplicate copies of records will be subject to a $35 fee, it is suggested that you make an additional copy of all records before giving them to other providers outside of Comprehensive Women's Healthcare.** This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization. I understand that the recipient may not lawfully further disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with people and/or organizations named in this form.

Signature:_____ Date:_____

Personal Representative Signature:_____ Relationship:_____

Office Use Only

Date: Received:_____ Date Released:_____ Provider Initials:_____ Sent By:_____