AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please Print

I authorize the release of my medical records **FROM** (previous health care provider information below):

Name _____

Address _____

Phone _____ Fax _____

I am releasing records **TO**

East Valley Women for Women
Address: 3317 S Higley Rd Ste 114-440, Gilbert, AZ 85297
Attn: Medical Records Phone: 480-597-4835
FAX: 833-450-5489 or Email: frontoffice@evwfw.com

Please release: All medical records Last 3 years

I understand that I may revoke this consent at any time and that, upon fulfillment of the above stated purpose this consent will expire one year following the date of signature.

Patient Name _____ Date of Birth _____

Signed _____ Dated _____