



## **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@evfw.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 \_\_\_\_\_

**Warning:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that dissemination, distribution or copying of this information is strictly forbidden. If you have received this message in error, please notify us immediately and destroy this message.