

Obstetrics & Gynecology

www.valleywomenforwomen.com or www.vwfw.com 855.329.8939 toll free fax (855-FAX-VWFW) 480.782.0993 phone

Signature:

South Gilbert – Main Office 3815 S Val Vista Dr Ste 101 Gilbert, AZ 85297

1501 N Gilbert Rd Ste 180 Gilbert, AZ 85234

Queen Creek

22711 S Ellsworth Rd Ste 104 Queen Creek, AZ 85142 Chandler

485 S Dobson Rd Ste 200 Chandler, AZ 85224 Chandler (Eddy OB/GYN office)

215 S Dobson Rd Chandler, AZ 85224

Mia Lynne Van Eken, DO, ΓΑCOG Denise Y Belisle, MD, FACOG Julie T Adams, DO, FACOOG Tracey K Peatross, MD, ΓΑCOG Jacqueline A Tetreault, MD, ΓΑCOG Kathryn M Connors, MD, FACOG Christina M Dave, MD Adriana Pritchard, MD, FACOG Briana T Wellington, MD, FACOG Amber L Vegh, MD, FACOG Dionne K Mills, MD Tiffany A DiGiacomo, MD Alissa M Floman, MD Cherady J Ketha, DO, FACOG Heather Γ Andrews, MD, ΓΑCOG Lilia Γ Sen, MD

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## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records between

Valley Women For Women, PC Attn: Medical Records 3815 S Val Vista Drive, Ste 101 Gilbert, AZ 85297 FAX 855-329-8939

Email: records@vwfw.com

and (name and address of health care provider): Name Address Fax I am releasing records (check only one) ☐ **TO** Valley Women for Women, PC. ☐ **FROM** Valley Women for Women, PC. Place a check mark below to indicate the records you wish to release: ☐ All Records ☐ Lab Reports □ Pap ☐ Ultrasounds □ Doctors' Notes □ Other Reason for release (please be as specific as possible): 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: D.O.B. / /

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Date \_\_\_