

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Drs. Goodman & Partridge, OB/GYN
Attn: Medical Records
PO BOX 6730
Chandler, AZ 85246
Phone/Fax (480) 821-3628

Send Records **TO** Drs. Goodman & Partridge, OB/GYN **FROM**
 FROM Drs. Goodman & Partridge, OB/GYN **TO**

Health Care Provider Name: _____ Phone: _____

Address: _____ Fax: _____

Records to Release All Records OB Records GYN Records Labs Imaging

Specific Date(s) -From _____ to _____

Other (please specify) _____

**Also include records about* communicable disease HIV neither

Reason for release Personal copy Referral / Continuity of Care Disability

Moving Transferring Care Insurance Legal Reason

Other (please specify): _____

**I understand that I may revoke this consent at anytime with the exception of records that have already been released and that any records received from another provider will not be released. I also understand there may be a fee for records released to the patient or another non-medical provider/facility, and that any such fee must be paid before the records will be released. Upon fulfillment of the above stated purpose this consent will expire in one year following the date of signature.*

Patient Name: _____ D.O.B. ____/____/____

Signature _____ Date _____

Relation to patient: Self Other (please specify): _____

General Information: Records are normally ready in seven to ten business days. Please fill out this form completely. Any items left blank will delay the release of your records. 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.