



MomDoc Medical Records
PO BOX 6730
Chandler, AZ 85246
Phone: 480-821-3600 Fax: 480-821-3628

Please fill out ALL information completely. **Any items left blank will prevent the timely release of records. Information cannot be changed, edited or added by MomDoc employees.** If you prefer to pick up your records in one of our **medical office** please specify when and which office. Records are normally available within seven to ten business days.

Send Records

TO MomDoc **FROM**

FROM MomDoc **TO**

Recipient's or Sender's 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 authorization 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 authorization will expire in one year following the date of signature.*

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

Signature _____ Date _____

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

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. **Please note we do not accept CD or Emailed records.**