RECORDS RELEASE

New Life Womens Health
10752 N 89th Place Suite 220B
Scottsdale, AZ 85260
Phone: 480-699-3089
Fax: 480-699-3083

PATIENT INFORMATION:

Patient Name:______________________________ DOB:__________ SS#:__________________

RELEASE INFORMATION:

I authorize____to provide the following records:
(Physician or Clinic/Facility)

☐ Complete copy of medical records ☐ Labs/Testing ☐ ART/IVF Info ☐ Other: ________________

Records are to be released to: ______________________________________

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DISCLOSURE INFORMATION & ACKNOWLEDGEMENT:

In addition to the general authorization to release records to the persons or entities above, I authorize the release of records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases, and communicable disease-related information to the person or entities listed above.

I **DO NOT** give my permission for the release of the following medical records:

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Disclosure of this information is requested for the following purposes:

☐ Personal ☐ Physician ☐ Insurance ☐ OB Continued Care ☐ Other (Specify________________

I understand that there is no charge if records are faxed or mailed to another healthcare provider for continued care. I understand that if these records are for my personal use, I will be charged $30.00. Insurance companies needing records for anything other than payment of a medical claim (i.e. life insurance); I will be charged $40.00. Attorneys requesting records for their patients will be charged $50.00.

I understand that this authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing written authorization of revocation. I understand that I cannot revoke this authorization retroactively for information already released.

____ ________________
Patient Signature **Date**

____ ________________
Legally Authorized Representative and Relationship to Patient **Date**