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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This release authorizes:

Valley Women For Women, PC
Attn: Medical Records
3815 S Val Vista Drive, Ste 101
Gilbert, AZ 85297
FAX 480-782-1330

to release to _____ the information specified below from the medical records maintained when I was treated in the above facility

- _____ Doctors' Notes
- _____ Lab Reports
- _____ Ultrasounds
- _____ Pap
- _____ Other

Reason for release (please be as specific as possible):

Send or fax medical records to: (Name/Address of Health Care Provider)

I understand that I may revoke this consent at any time and that, 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 _____

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.