Valley Women for Women P.C.
Obstetrics & Gynecology

www.vwfw.com - (480) 782-0993 – (855) FAX-VWFW

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 _____

Phone _____ 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 _____ Date of Birth _____

Signed _____ Dated _____

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.