201 W. Guadalupe Rd, Ste 310 Gilbert, AZ 85233
Phone: 480-813-0944 Fax: 480-813-0038

- ☐ Eric Hazelrigg, MD
- ☐ Joel Falk, MD
- ☐ Susan Kudlinski, MD
- ☐ Krystal Mazola, MD
- ☐ Rosemary Boyle-Forsythe, RNP-C
- ☐ Patricia Washkowiak, RNP-C
- ☐ Cyndy Churgin, RNP-C

Patient Information

Name: _____DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Release Information

Release Records **from** CWH to:	Release Records **to** CWH from:
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Specify records: Please check all that that is applicable to be released

Medical records shall include all confidential AIDS/HIV, alcohol, drug and mental health related information, unless specified otherwise.

- ☐ **ALL RECORDS**
- ☐ Lab/Pathology Reports
- ☐ Pap Smears
- ☐ Operative Reports
- ☐ Pre/Post-Natal Records
- ☐ Progress Notes
- ☐ Ultrasounds
- ☐ Mammograms
- ☐ Other: _____

Please check reason for request:

☐ Moving ☐ Transferring Care ☐ Patient's Request ☐ Continuation of Care ☐ Other:_____

This authorization shall become effective immediately and shall remain in effect for one year from date of signature unless a different date is specified here _____. **Personal requests for duplicate copies of records will be subject to a $35 fee, it's suggested that you make an additional copy of all your records before giving them to other providers outside of Comprehensive Women's Healthcare.** This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, expect to the extent that the disclosing party or others have acted in reliance upon this authorization. I understand that the recipient may not lawfully further disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with people/and or organizations named in this form.

Signature:_____ Date: _____

Personal Representative Signature:_____ Relationship: _____

*****PLEASE NOTE COPYING OF RECORDS CAN TAKE UP TO 7 BUSINESS DAYS TO BE PROCESSED*****

Office Use Only

Date Received: _____ Date Released: _____ Provider Initials: _____ Sent By: _____

PLEASE DO NOT FAX RECORDS IF MORE THAN 10 PAGES