

Records Release Form

Please print this form, fill it out, and either fax it or bring it with you for your visit. Thank you!



Patient Information

Last Name, First Name, Middle Initial

Street Address

City State ZIP

Phone Numbers that are OK to Call

() Home Cell Work

Date of Birth

Dr.
CCFW Physician

Social Security No.

Tempe Office

6301 S. McClintock Dr.,
Suite 215
Tempe, AZ 85283
Phone: (480) 820-6657
Fax: (480) 730-0803

Gilbert Office

2550 E. Guadalupe Rd.,
Suite 109
Gilbert, AZ 85234
Phone: (480) 505-4475
Fax: (480) 505-4252

Release

Please check the appropriate box:

- I hereby authorize Contemporary Care for Women to send/release photocopies of medical records concerning the above named patient **to the provider listed below.**
- I hereby authorize the provider listed below to send/release photocopies of medical records concerning the above named patient **to Contemporary Care for Women.**

(Name of Company or Physician authorized to receive/release records)	Telephone No.
Address	Fax No.
City	State ZIP

Medical records shall include all confidential Aids, Communicable Disease, HIV-related information, confidential alcohol or drug-related information, and mental health diagnosis/treatment information. Release the following described medical records only (specify type and dates):

- ALL _____
- Specify other: _____

Reason for Release

- Moving New Insurance Plan Consult/2nd Opinion Changing Doctor
- Other, please explain: _____

This consent will expire sixty (60) days after the date signed below. I may revoke this authorization at any time providing I notify Contemporary Care for Women, in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I hereby release CONTEMPORARY CARE FOR WOMEN FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.

Patient Signature

Date

Patient Legally Authorized Representative

Relationship

Date