Arcadia Well Woman
7514 E. Monterey Way Suite 3
Scottsdale AZ 85251
Phone: 480-421-9938
Fax: 480-429-2354

Records Release Form

RE: Release of Medical Records for_____

Date of birth_____, SSN_____

Please release my medical records from (office) _____

Name of provider_____

Provider's address_____

Provider's phone number_____

Provider's fax number_____

This authorization ends:

On (date) _____ (or) Good for one year_____

To: Arcadia Well Woman
Dale Ann Dorsey RNP-C

___Please release **ALL** my medical records to the above name.

___Please release my **Most Recent** medical records, including but not limited to, pathology, laboratory test results, diagnostic test, and radiology.

___Please release my most recent ___Pap __Labs __Radiology __Pathology

- I hereby authorize the release of my medical records as provided above.
- The protected health information disclosed may or may not be subject to re-disclosure by the recipient.
- I have the right to revoke this authorization.
- Information related to the following will <u>not</u> be disclosed unless initialed below:
  ___ Drug/alcohol treatment ___ HIV-related info ___ Mental health info

Patient Signature_____ Date_____
Witness Signature_____ Date_____