1166 E. Warner Rd. Ste.101
Gilbert, AZ 85296
480-339-7119
Fax: 480-339-7109

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize **Women's Health Innovations of Arizona**
To _____send _____receive the records of:

____ (__________)
(Name of client) (Date of birth)

_____to and ______from:

____
(Facility/Provider)

____
(Address)

Nature of information to be disclosed:
__Labs
__Clinical Notes
__Diagnosis
__Treatment plan
__Health record
__Other:____

For the purposes of ____
(State specific purpose of information to be disclosed)

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to East Valley Maternal Wellness. I understand that a revocation is not valid to the extent that East Valley Maternal Wellness has acted in reliance on such authorization. This authorization is valid until _________.
(Date)

A copy of this release shall have the same force and effect as the original.

______________________________________ ____________________________________
(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

______________________________________ ____________________________________
(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

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