

## **AUTHORIZATION TO RELEASE MEDICAL RECORDS**

I authorize the release of my medical records between

Lilac Ob-Gyn ATTN: Medical Records 655 S Dobson Rd Ste 101 Chandler, AZ 85224

Fax: 480-687-1802 Phone 480-459-2555

Email records@lilacob.com

and (name and address of health car	e provider):	
Provider or Practice Name: _		
Provider Address:		
Provider Phone:	Fax or Email:	
I am releasing records (choose ONE)	<b>TO</b> Lilac Ob-Gyn	<b>FROM</b> Lilac Ob-Gyn
Which medical records do you wish t	o release (please be spec	ific)?
ALL Records	Ultrasound	Doctors' Notes
Lab Reports	Pap	Other:
Reason for release (be specific):		
This consent will continue indefinitel	y unless I revoke it in writ	ing.
Patient Name	Patient D	.O.B
Signature	Date	

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. Copyright © 2021 Lilac Ob-Gyn All Rights Reserved.