Lilac Ob-Gyn
655 S. Dobson Rd. Ste 101
Chandler, AZ 85224

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 care provider):

Provider or Practice Name: _____

Provider Address: _____

Provider Phone: _____ Fax or Email: _____

I am releasing records (choose ONE) ____ **TO** Lilac Ob-Gyn ____ **FROM** Lilac Ob-Gyn

Which medical records do you wish to release (please be specific)?

____ ALL Records ____ Ultrasound ____ Doctors' Notes

____ Lab Reports ____ Pap ____ Other: _____

_____

_____

Reason for release (be specific): _____

_____

_____

This consent will continue indefinitely unless I revoke it in writing.

Patient Name _____ Patient D.O.B. _____

Signature _____ Date _____