Brunilda Rosario D.O., F.A.C.O.G

GYNECOLOGY / OBSTRETICS / INFERTILITY

AUTHORIZATION FOR REQUEST / RELEASE OF MEDICAL RECORD

Name: _____DOB: _____Date:_____

I hereby authorize the release of all my records and test results, including HIV test results in your possession regarding my illness and/or treatments:

___All available records ___Past 12 months ___from_____to_____

Please specifically include the following items:

1. _____
2. _____
3. _____

___To ___From New Start Women's Care

700 N. Estrella Parkway Suite 125

Goodyear, AZ 85338

P: 623-536-2413 F: 623-536-2909

___To ___From

Name/Medical Facility:	
Address:	
Phone:	Fax:

I understand that this authorization is voluntary. I also understand that I will ONLY be given copies of records created or ordered by this office. If you need records from other physicians' offices, or laboratories, please contact those offices for copies.

I understand that I may revoke this consent at any time, by submitting such a request in writing, except where information has already been released. The authorization is valid for sixty (60) day period from the date it is signed.

Patient Signature Date