Arizona Specialized Gynecology

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Medical Records Release Form

I authorize Arizona Specialized Gynecology to release and/or recieve my personal confidential health information. By signing this form, I understand releasing a copy and/or summary of my medical records to the provider/facility/entity listed below may include my history of any sexually transmitted diseases and/or any other gynecological health related issues.

Patient name: _____ DOB: _____

☐ Sending Records ☐ Requesting Records

The information you may release subject to this signed release form is as follows:

☐ Complete Medical records
☐ Pathology Reports
☐ Consultations
☐ Lab Reports
☐ Operative Reports
☐ Other

Release/Recieve my confidential health information to/from the following provider/facility/entity:

Name: _____

Phone: _____

Fax: _____

_____ _____

Signature **Date**