

**DEBORAH WILSON M.D ALEXANDRA KIDD M.D.
PEGGY DECAROLIS WHCNP, PAULA MAZZACANO WHCNP
ROBIN PARRY C-NP**

**Authorization for Release of Medical Information to
Spouse, Parent, Guardian or other
Specify**

I, _____ give express

_____ written consent to the physicians and staff of this practice to disclose any information

pertaining to my health and medical records _____
Specify full name

Who is spouse/friend/parent, guardian.

SIGNATURE: _____ DATE: _____

I decline release of any information regarding my medical health: _____

SIGNATURE: _____ DATE: _____

WITNESS: _____

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GYNECOLOGY
ADVANCED LAPAROSCOPIC SURGERY

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FAX 480-860-6314

AUTHORIZATION AND RELEASE OF MEDICAL RECORDS

Patient Name: _____ D.O.B. _____

I, the undersigned, request that the person or entity indicated below be provided with a copy of Medical records, documents, reports, clinical abstracts, histories, chart of any kind or description related to the care or services furnished to the person or entity indicated below.

In addition to the general information to release of Medical Records, I authorize the release of records regarding testing, diagnosis, and or treatment for HIV, related illness, AIDS related disease, and communicable disease related information to the person or entity indicated below.

Medical Records Information FROM: _____

Medical Record Information to be SENT TO: _____

Specific information requested _____

This authorization is valid for six months from the data of signing, I may revoke this authorization at any time by providing written notice of revocation. I acknowledge, however, that I may not revoke the authorization retroactively for any information that has already been released.

Patient Signature: _____ Date: _____

patient is unable to consent by reason of age, or some other factor, state reason: _____

Legally authorized Representative: _____

Relationship to patient: _____ Witness: _____