AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO BETHANY WOMEN'S HEALTHCARE

PHONE: (602) 973-3200 FAX: (602) 795-3714

DATE:___________________

I HEREBY AUTHORIZE:

____
(COMPANY, PERSON, FACILITY)

____
(ADDRESS)

____________________________ ____________________________
(PHONE) (FAX)

TO RELEASE MY MEDICAL RECORDS TO BETHANY WOMEN'S HEALTHCARE

PLEASE INCLUDE THE FOLLOWING DATED FROM:

____

I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to alcohol, drug and psychiatric treatment, AIDS and/or HIV testing, and/or other sexually transmitted infections. I specifically consent to the release and disclosure of this information. I understand that transmitting records by facsimile may breach the confidentiality of my records.

______________________________________ ______________________________________
PRINT NAME SIGNATURE

____
OTHER NAME(S) USED

______________________________________ ______________________________________
DATE OF BIRTH SOCIAL SECURITY NUMBER