Scottsdale Personal OB-GYN
8414 E. Shea Blvd, Suite 103
Scottsdale, AZ 85260
Office (480)794-1000 Fax (480) 860-2433
Afshin Malaki, MD

Medical Records Authorization Release From

Patient Information: (Please Print)

_____

Full Name **Address** **City** **State** **Zip**

___/____/_____ (_____)_____ _____

Date of Birth **Daytime phone (cell)** **Previous Name**

I authorize the following medical facility: Medical facility name: _____
phone #: _____ fax #: _____

to release my medical records to: Scottsdale Personal OB-GYN (see above for contact info)

I would like to have the following medical records released:
□ My complete records (including notes, labs, pathology and radiology reports): _____
□ All medical records but only related to (specify condition or treatment, etc.): _____

Dates of information to be released: From: _____ To: _____
(month/year) (month/year)

I do NOT want the following information disclosed:
□ Alcohol/Drug Abuse □ HIV Test Results □ Mental Health/Developmental Disabilities □ Other: _____

Purpose (Check all that apply):
□ Transfer of care □ Insurance Eligibility/Benefits □ Personal (at my request) □ Other: _____

Expiration: This authorization is good until the following date: ____/_____/_____
If this item is left blank, the authorization will expire in one (1) year from the date signed.

I may revoke this authorization at any time by providing written notice. I hereby waive all provisions of law and privileges relating to disclosures hereby authorized. I understand that I might be charged a reasonable fee for the record copies by the releasing medical facility. For the exact fee I will contact the releasing facility.

Signature: _____ Date: _____