UNIVERSITY OBSTETRICS AND GYNECOLOGY
Eric G. Huish, D.O., FACOOG
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AUTHORIZATION TO RELEASE MEDICAL RECORDS
FROM
UNIVERSITY OBSTETRICS & GYNECOLOGY

4915 E. Baseline, Bldg #10, Suite 126
Gilbert, Arizona 85234
Phone 480-969-3096 Fax 480-969-0963

Patient Name:_____ Date of Birth:_____

Address:_____ SS#:_____

_____ Home phone:_____

_____ Work phone:_____

I hereby authorize University OB-GYN to release photocopies of all medical records concerning the above named patient to:

_____

_____

_____

I hereby authorize hereof, "MEDICAL RECORDS" shall include all confidential HIV-related information and/or confidential communicable disease-related information (as defined in A.R.S. section 36-661), confidential alcohol or drug abuse-related information (as defined in 42 CFR section 2.1 ET SEQ) and confidential mental health diagnosis / treatment information unless otherwise indicated below.

_____ Release a copy of **ALL** medical records

_____ Release **ONLY** the records specified as follows:_____

_____

Patient signature:_____ Date:_____