reproductive health center

AUTHORIZATION TO RELEASE MEDICAL RECORDS

NOTE TO NEW PATIENTS: *PLEASE SEND OR FAX THIS COMPLETED FORM TO YOUR PREVIOUS DOCTOR SO THAT HE/SHE CAN RELEASE A COPY OR YOUR MEDICAL RECORD TO OUR OFFICE PRIOR TO YOUR APPOINTMENT.*

I do hereby consent and authorize release of my medical records and data pertaining to:

Patient name: _____ Date of Birth _____

Previous Last name: _____ Social Security/Acct Number: _____ (Optional)

Address: _____

City, State & Zip Code: _____ Phone: _____

Doctor's Practice:	Office phone
Office Address:	Office fax

Release of Records from the following physician/ facility and/or those directly associated in my medical care:

_____ All Records _____ All records between the dates of _____ & _____

_____ Labs only _____ Records pertaining to _____

Please Specify method of Release:

_____ Pick up by patient _____ Fax to Dr. Hutchison: (520) 733-0771 _____ Fax: _____

_____ Email to patient: _____

_____ Mail to Dr. Hutchison's office: _____ Mail to: _____ Patient _____Another Doctor's office

Scot M. Hutchison, MD
Reproductive Health Center
4518 E. Camp Lowell
Tucson, AZ 85715

Name of Facility/ Doctor's name _____

Address _____

City, State, Zip Code _____

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.

This consent will expire six (6) months from the date on which it is signed.

Patient's Name: _____

Patient's Signature: _____ Date: _____