

Tami Dairiki, M.D.
Patty Hastings RN, WHNP-C
Desert Mountain OB/GYN
14220 Northsight Blvd #150 Scottsdale, AZ 85260
Tele: (480) 585-0804 Fax: (480) 585-0828

MEDICAL RECORDS AUTHORIZATION RELEASE

PATIENT NAME: _____

PRIOR NAME: _____
(If seen under another name)

DATE OF BIRTH: ___/___/___

SOCIAL SECURITY NO.: ___/___/___

I authorize: _____

To release my medical records to: _____

Information to be released will consist of all your records; including your progress notes, radiology reports, labs, HIV, and other confidential tests **UNLESS OTHERWISE INDICATED IN WRITING BELOW.**

I may revoke this authorization at any time by providing written notice of revocation. I may not revoke the authorization retroactively for information already released. I hereby waive all provisions of law and privileges relating to disclosures hereby authorized.

I understand that there is no charge when records are mailed to a medical provider for continuing care. I also understand a **\$25.00 fee will be charged for the copying of any records** mailed to any party other than a medical provider including myself. Please allow 72 hours for the completion of medical record requests.

Patient Signature

Dated