

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

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I authorize \_\_\_\_\_  
(Providers Name, Practice Name or Hospital we are requesting records from)  
to disclose protected health information (“PHI”) from the health records.

**Patient name:** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Patient Address** \_\_\_\_\_

**Patient Phone number:** \_\_\_\_\_

I authorize PHI from \_\_\_\_\_ (date) to \_\_\_\_\_ (date) to be disclosed to:

Requesting Records from \_\_\_\_\_

Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Specific description of the information to be disclosed:

- \_\_\_\_\_ Progress Notes
- \_\_\_\_\_ Operative Reports
- \_\_\_\_\_ X-Ray/Ultrasound Reports
- \_\_\_\_\_ Lab Tests
- \_\_\_\_\_ Other \_\_\_\_\_

Specific description of the purpose of the disclosure:

- \_\_\_\_\_ Continued Patient Care
- \_\_\_\_\_ Other \_\_\_\_\_
- \_\_\_\_\_ The disclosure is at my (the patient’s) request. (Additional fees may apply for Printed copies.)

I understand the matters discussed on this form. I release the provider, its employees, officers, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship to Patient