



desert bloom
Obstetrics & Gynecology

Desert Bloom Obstetrics & Gynecology

6452 E. Carondelet Dr.
Tucson AZ, 85710

Medical Record Request

I authorize _____
(Releasing Physician/Facility)

(Address)

(Phone Number and Fax Number)

To release my medical information, including the diagnosis and records of any treatment or examination rendered to me during the period:

From: ____ / ____ / ____ To: _____
(Dates of Service)

Excluding _____

No exclusions

These records are to be released to:
Desert Bloom Obstetrics & Gynecology
6452 E. Carondelet Dr.
Tucson, AZ 85710
Office: (520) 885-5300 / Fax: (520) 885-5309

Print Name (*please print*): _____ Date of Birth: _____

Signature: _____ Date: _____

Requesting Provider: _____ Witness: _____

This authorization will expire 12 months from the signature date or when the signer withdraws authorization.