Desert Bloom OB/GYN

Medical Record Release

I,_____ authorize Desert Bloom Ob/Gyn to release my medical information, including the diagnosis and records of any treatment or examination rendered to me during the period below:

From: _____ to_____

Excluding_____ No Exclusions ☐

Reason for request of records:_____

If transfer of care, please state reason:_____

Release records to: _____
(Physician's Name)

Physician Office Address: _____

Physician Office Phone: _____

Physician Office Fax: _____

Print Name: _____

Date of Birth: _____

Signature: _____

Date: _____

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