



**AZ Maternity &
Women's Clinic**
OB/GYN

14961 W. Bell Rd. #175

Surprise, AZ 85374

Phone # (623) 547-7205 Fax # (623) 243-6733

Medical Records Release Form

I authorize & consent AMWC to release or receive records.

Incoming Records To AMWC Outgoing From AMWC

Date requested: _____

Patient Name: _____ DOB: _____

Address: _____

Name of Physician: _____

Address: _____

Phone number: _____ Fax: _____

Requesting the Following Records

Lab Reports Imaging Total Records

other request: _____

I understand I have the right to refuse this authorization in writing and AMWC is released from all legal liability that may arise from the released information requested.

Also, a \$25 fee will be required for second time records printed solely for patient.
Records may take up to 3-5 Business Days for completion.

Signature: _____