MomDoc Medical Records

PO BOX 6730

Chandler, AZ 85246

**Phone: 480-821-3600 Fax: 480-821-3628**

Please fill out ALL information completely. **Any items left blank will prevent the timely release of records**. **Information cannot be changed, edited or added by MomDoc employees.** If you prefer to pick up your records **in one of our medical office** please specify when and which office. There is a $15 fee for personal records over 15 pages. This fee must be paid before the records will be released. Records are normally available within seven to ten business days.

**Send Records**

□ **TO** MomDoc **FROM**

□ **FROM** MomDoc **TO**

Recipient’s or Sender’s Name*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Address: Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Unit#\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_*

*Zip code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Records to Release**

□ All Records □ OB Records □ GYN Records □ Labs □ Imaging

□ Specific Date(s) -From \_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_

□ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\_\_\_\_\_* **Initials** I understand that the information released may include information that may indicate the presence of communicable or venereal diseases or HIV. **I recognize that by not initialing, my records may not be sent.**

**Reason for release**

□ Personal copy □ Referral / Continuity of Care □ Disability □ Moving □ Transferring Care

□ Insurance □ Legal Reason □ Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*I understand that I may revoke this authorization at anytime with the exception of records that have already been released and that any records received from another provider will not be released. Upon fulfillment of the above stated purpose this authorization will expire in one year following the date of signature.*

Patient Name(**Printed**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient: □Self □Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When MomDoc releases your records to others, such as insurers, it emphasizes that the records are confidential.** This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. ***Please note we do not accept CD or Emailed records*.**