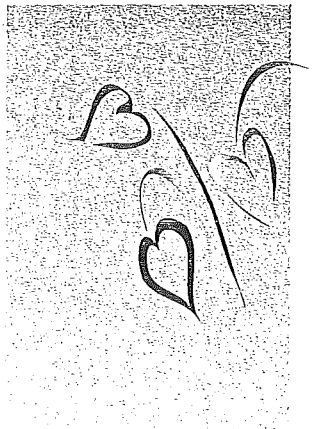

COPPERSTATE
OB/GYN
ASSOCIATES LTD.

Women's Health Specialists

5550 E. Hampton St.
Tucson, AZ 85712
Phone: 520-721-8605
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copperstateobgyn.com

REQUEST FOR MEDICAL RECORDS

Patient's name _____

Address _____

Phone #: _____ DOB: _____ SS#: _____

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship: [ ] Parent or guardian of minor patient
[ ] Guardian or conservator of an incompetent patient
Beneficiary of personal representative of deceased patient

This authorization applies to the following information:
[ ] All the records or
[ ] The portion of records concerning: _____

_____
(Specify type of disease, accident, dates of treatment, other portion of records you are interested in.)

A specific authorization is required to release information regarding the following:

	Yes	No	Initial
HIV Information	[ ]	[ ]	_____
Drug/Alcohol Information	[ ]	[ ]	_____
Mental Health Information	[ ]	[ ]	_____

Reason for copies of medical records: _____

I hereby authorize medical information concerning (Patient's name) _____

TO: _____ FROM: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

This authorization is effective now and will remain in effect 30 days from date signed.

I understand I may receive a copy of this authorization. Please indicate preference: [ ] Pick up [ ] Mail

ATTENTION: These copies are intended only for the individual to whom it is addressed. It contains information that may be confidential under the law. If you are not intended recipient or agent responsible for delivering these copies, do not read, copy or distribute this information. If you have received these copies in error, please notify us immediately, by collect phone call, and return the copies by mail. THANK YOU.

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