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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records between

Serenity Women's Care

8070 E Morgan Trl, Ste. 120

Scottsdale, AZ 85258

and (name and address of the health care provider):

Name	-	
Address		
I am releasing records (Check only one)	TO Serenity	Women's Care
	FROM Serenity Women's Care	
Place a check mark below to indicate the re	cords you wish to re	elease:
All Records Lab Reports	Рар	Ultrasounds
Doctor's Notes Other		
Reason for release (please be as specific a		
I understand that I may revoke this consent		
purpose this consent will expire one year for	llowing the date of	signature.
Patient Name		D.O.B <u>/</u> //
Signature		Date / /