

Request of Records Release Form

Physician or Practice Name

Address

Telephone Number/FAX

I authorize and request a copy of my medical records for continuing medical care as follows:

All Medical Records

OB/GYN Records only

Laboratory Results

Radiology/Ultrasound

Other _____

Dates limited to _____

I understand that the release of medical records may include results of communicable/sexually transmitted diseases including AIDS/HIV, alcohol and substance abuse

I consent to the release of these records.

Patient Name (print)

Previous Name

Signature

Date

Social Security Number

Date of Birth

Release Records to:

David N. Kells, M.D. FACOG
Boojum Obstetrics & Gynecology, PC
655 South Dobson Road, Suite 101
Chandler, AZ 85224

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