Authorization for Release of Medical Information
24 - 48 hour Processing Time

Rachel Spieldoch M.D.
10617 N. Hayden Road Suite B-102
Scottsdale, AZ 85260
Phone: (480) 483-9011 Fax: (480) 483-2803

Records Going To:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Fax:** _____

☐ **Pick Up** ☐ **Fax**

I authorize the release of records, including those that may contain confidential HIV/AIDS related information, confidential communicable disease related information, information relating to mental health and/or alcohol/drug use. Please release the following records:

☐ **Lab Report (Blood work, Pap test)** _____
Date of Service

☐ **Operative/ Pathology Report** _____
Date of Service

☐ **Gynecological Reports (Ultrasounds, Biopsy's, etc.)** _____
Date of Service

☐ **OR COMPLETE RECORDS**

Patients Name: _____ **DOB:** _____

Patient/Legal Guardian Signature: _____ **Date:** _____

This Consent will serve as an open release unless otherwise stated. Patients Initials: _____