

**SOUTHWEST FERTILITY CENTER**  
**Sujatha Gunnala, M.D., A.B.O.G., F.A.C.O.G**  
 3125 N. 32<sup>ND</sup> ST. SUITE 200, PHOENIX, AZ 85018  
 PH (602) 956-7481 FAX: (602) 956-7591

**RECORDS RELEASE AUTHORIZATION**

RELEASE RECORDS TO:  <hr/> <hr/> <hr/> PHONE # _____ FAX # _____	RELEASE MEDICAL RECORDS FROM:  <hr/> <hr/> <hr/> PHONE: _____ FAX: _____
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RECORDS NEED TO ARRIVE PRIOR TO PATIENT'S APPOINTMENT ON:
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I hereby authorize the release of photocopies of the following medical records and /or x-ray films in the possession or control of the above named medical facility, its employees and /or agents. For the purposes hereof, "medical records" and "x-ray films" shall include all confidential HIV-related information (as defined in A.R.S. Section 36-661), confidential communicable disease-related information (as defined in A.R.S. section 36-661). Confidential alcohol or drug abuse-related information (as defined in 42 CFR section 2.1 ET SEQ.), and confidential mental health diagnosis/treatment information.

<input type="checkbox"/> HSG X-RAY REPORT	<input type="checkbox"/> HSG X-RAY FILMS	<input type="checkbox"/> LAB REPORTS
<input type="checkbox"/> ULTRASOUNDS	<input type="checkbox"/> LAPAROSCOPY REPORT	<input type="checkbox"/> PAP SMEAR RESULTS
<input type="checkbox"/> ANY GYN SURGERIES	<input type="checkbox"/> GYN RECORDS ONLY	<input type="checkbox"/> ALL MEDICAL RECORDS
<input type="checkbox"/> SEMEN ANALYSIS	<input type="checkbox"/> SPOUSE RECORDS	<input type="checkbox"/>

PLEASE GIVE SPECIFIC REASON FOR RECORDS REQUEST:
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Patient's Name and Address: (please print, include previous last name change)  <hr/> <hr/> <hr/>	Date of Birth: _____  Social Security Number: _____  Phone Number: _____  SPOUSE NAME: _____
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Patient's Signature:	Date:
Witness Signature:	Date: