

**Authorization to Release Medical Records**

**C. Steven Plimpton, M.D., P.C.**

**Ellen Franklin, CNM, MS**

515 East Thomas Road

Phoenix, AZ 85012

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Records to be released from: \_\_\_\_\_

Records to be released to: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

*I hereby authorize the release of photocopies or fax copies of the following medical records, including 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 A.R.S. 36-661 and in 42 CFR section 2.1 Et Seq.), and confidential mental health diagnosis/treatment information.*

Please release the following information:

Medical records of the past two (2) years of treatment

Prenatal records from care received \_\_\_\_\_.

CEsarian Section records from patient's delivery in \_\_\_\_\_.

Other: \_\_\_\_\_.

Reason for Release Request: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

For records to be released TO our office, please send records to the following location:

515 East Thomas Road  
Phoenix, AZ 85012  
(602) 241-1717  
FAX (602) 265-7216

6707 North 19th Avenue Suite 222  
Phoenix, AZ 85015  
(602) 258-2264  
FAX (602) 258-1710