Authorization to Release Medical Records

Address: City, State, Zip:	Practice Name:	Doctor Name:
To release medical records and data pertaining to: atient Name: ate of Birth: Phone Number: treet Address: City, State, Zip Code: Please specify what records should be released: All records All records All records between the dates of and Records pertaining to Release records to: Troche Fertility Centers 17612 N. 59th Avenue, Suite 100 Glendale, AZ 85308 (602) 993-8636 FAX # (602) 993-2528 I understand that I may revoke this authorization at anytime, except to the extent that action based on th authorization has already been taken. This consent will expire six (6) months from the date on which it signed. Patient's Name:	Address:	City, State, Zip:
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Records Release Previous Doc Rev 1/2013