

**DEBORAH WILSON M.D RACHEL SPIELDOCH M.D.  
DEBRA WICKMAN M.D.  
PEGGY DECAROLIS WHCNP, PAULA MAZZACANO WHCNP  
BARBARA HIGGINS WHCNP, ROBIN PARRY C-NP**

**Authorization for Release of Medical Information to  
Spouse, Parent, Guardian or other  
Specify**

I, \_\_\_\_\_ give express

written consent to the physicians and staff of this practice to disclose any information

pertaining to my health and medical records \_\_\_\_\_  
Specify full name

Who is spouse/friend/parent, guardian.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**I decline** release of any information regarding my medical health: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

**DEBORAH WILSON M.D. JENNIFER SIMONE M.D.  
RACHEL SPIELDOCH M.D.  
PEGGY DECAROLIS WHCNP, PAULA MAZZACANO WHCNP  
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*GYNECOLOGY  
ADVANCED LAPAROSCOPIC SURGERY*

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**AUTHORIZATION AND RELEASE OF MEDICAL RECORDS**

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

I, the undersigned, request that the person or entity indicated below be provided with a copy of Medical records, documents, reports, clinical abstracts, histories, chart of any kind or description related to the care or services furnished to the person or entity indicated below.

In addition to the general information to release of Medical Records, I authorize the release of records regarding testing, diagnosis, and or treatment for HIV, related illness, AIDS related disease, and communicable disease related information to the person or entity indicated below.

Medical Records Information FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Record Information to be SENT TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific information requested \_\_\_\_\_

This authorization is valid for six months from the data of signing, I may revoke this authorization at any time by providing written notice of revocation. I acknowledge, however, that I may not revoke the authorization retroactively for any information that has already been released.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

patient is unable to consent by reason of age, or some other factor, state reason: \_\_\_\_\_

Legally authorized Representative: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Witness: \_\_\_\_\_