

Desert Bloom OB-GYN

Medical Record Release Request

I authorize _____
Releasing Physician / Facility

Address

Phone Number

to release my medical information, including the diagnosis and records,
of any treatment or examination rendered to me during the period
from _____ to _____.

No Exclusions Excluding _____

These records are to be released to:

**Desert Bloom OB-GYN
6504 E. Carondelet Drive
Tucson, AZ. 85710
(520) 885-5300 office
(520) 885-5309 fax**

Print Name: _____

Date of Birth: _____

Signature: _____

Date: _____

Witness: _____

Desert Bloom OB-GYN Employee