Jeffrey T Arrington MD PC
12842 S 3600 W, Suite 200
Riverton, UT 84065
P: 801-433-2190
F: 801-433-2191

MEDICAL RECORDS RELEASE REQUEST & AUTHORIZATION

Patient Full Name
Address
Date of Birth
Telephone

Dear Healthcare Provider: On behalf of Jeff Arrington, MD FACOG and Endowest – the endometriosis specialty clinic, we respectfully request the release of Medical Record(s) on behalf of the above-named patient.

From: _____ _____
Surgeon Clinic

Information Requested: **Surgical pathology reports (if any) Last 6 years, operative notes (if any) Last 6 years, surgical photos (if any) Last 6 years, imaging and/or diagnostic report(s) within the last 6 months**.

Restrictions and/or Exclusions (if any): No other records are necessary or specifically approved for release.

Purpose of Release: SURGICAL CONSULT. PLEASE RELEASE DIRECTLY TO THE PATIENT IN ADVANCE OF THEIR CONSULT or Fax to 801-433-2191

Name of person completing this form and relationship to patient:

Name: _____ Relationship: _____

Signature:_____ Date: _____

THANK YOU FOR YOUR KIND ASSISTANCE.

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Dear Provider(s): We greatly appreciate your kind courtesy and support on behalf of your above-named patient. Please make a copy of this release for your records. Thank you. Please call us at 801-433-2190 with any questions.