

Received _____ Initials _____ Account Code _____

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The Doctors Women Trust - The Lifetime of Care They Deserve

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(1) Please RELEASE my medical information to: Please OBTAIN information FROM:

Name of Physician, Hospital or Self *Address* *City* *State* *Zip*

Phone *Fax*

(2) Patient information:

Print Patient's Name *(other name used or AKA?)* *Date of Birth*

Street Address *City* *State* *Zip*

Phone *E-Mail* *Fax*

(3) **Purpose for Records Request:** _____
(personal use, primary care physician, transferring care, insurance change or insurance, 2nd opinion, referral)

(4) I hereby authorize the release of the information specified below:

- Most Recent Visit Notes
- Most Recent Pap Smear HPV
- Most Recent Labs ONLY ***Include HIV/Aids AND SEXUAL TRANSMITTED DISEASE INFO ? *** yes no
- Most Recent Mammogram
- Most Recent Ultrasound
- Surgery/Procedures (Operative Report and Pathology Report)
- Obstetrical Records (Pregnancy) ***Include HIV/Aids AND SEXUAL TRANSMITTED DISEASE INFO ? *** yes no
- All Records ***Include HIV/Aids AND SEXUAL TRANSMITTED DISEASE INFO ? *** yes no
- Other: _____

(5) Please allow Orange Coast Women's Med. Group 2 WEEKS for your request to be processed. \$15 fee for release of more than 10 pages / No fee for records released to an MD's office

I understand that the authorization for disclosure of records as detailed above, unless specifically limited by me in writing, will extend to all aspects of treatment provided. These records may include testing for all sexual transmitted diseases, AIDS, and hepatitis, as well as drug, alcohol and/or psychiatric info. Orange Coast Women's Medical Group is hereby released from all legal responsibility of liability for the release of the above disclosure of information. I have the right to withdraw this authorization at any time and that such revocation must be in writing.

(6) Patient's Signature: _____ (7) Date: _____

(8) If patient is a Minor: _____ (9) Relationship of Patient Representative of Patient: _____

Signature of Patient Representative

Only required for Spouse's records to be released;

(11) Spouse's Signature: _____ (12) Spouse Print name: _____