Orange Coast Women's Medical Group
24411 Health Center Dr. #200, Laguna Hills, CA 92653 * Phone#: 949-829-5500 ext. 1616
Fax#: 949-581-9158 * Email: medicalrecords@ocwmg.com

ORANGE COAST WOMEN'S MEDICAL GROUP

AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. ☐ **Please RELEASE my medical information to**: ☐ **Please OBTAIN my medical information from**:

_____
Name of Physician, Hospital, or Self Phone# Fax#

_____
Address City State Zip

2. **Patient Information**:

_____
Print Patient Name (Other names used/AKA) Date of Birth

_____
Street Address City State Zip

_____
Phone # Fax # Email Address

3. **Purpose for Records Request**: _____ (i.e. Personal use, primary care physician, transferring care, insurance change, for insurance purposes, 2nd opinion, referral)

4. **Please specify records to be disclosed by checking the appropriate box ***:

- ☐ 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 ***Please allow 48hrs for all ultrasound disks to be made***
- ☐ Surgery/Procedure (Operative Report and Pathology Report)
- ☐ Obstetrical Records (Pregnancy) ***Include HIV/AIDS and Sexually Transmitted Diseases Info** ☐ Yes ☐ No
- ☐ All Records ***Include HIV/AIDS and Sexual Transmitted Disease Info*** ☐ Yes ☐ No

Other: _____

5. **Please note*** Please allow 10 business days for your request to be processed. There will be a $15 fee for the release of more than 10 pages / No Fee for records that are released to an MD's office or Hospital**

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 information. 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.

Date: _____ Signature: _____ Print Name: _____

Date: _____ Spouse's Signature: _____ Print Name: _____
(required for spouses records only)

Date: _____ If Patient is a Minor: _____ Relationship: _____