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

ORANGE COAST WOMEN'S MEDICAL GROUP

AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. ☐ **RELEASE my medical records to OCWMG** ☐ **OBTAIN my medical records from a previous physician or facility**

_____

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**

_____

Phone # 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 *** ☐ Yes ☐ No
- ☐ Most Recent Mammogram
- ☐ Most Recent Bone Density
- ☐ Most Recent Ultrasound report ☐ CD ***$15 fee* **Allow 48hrs for all ultrasound disks to be made****
- ☐ Surgery/Procedure (Operative Report and Pathology Report)
- ☐ Obstetrical Records ***Include HIV/AIDS and Sexually Transmitted Diseases*** Yes ☐ No ☐

5. **Please note *** Allow 10 business days for your request to be processed. There will be a $25 fee for the release of more than 10 pages / No Fee for records that are released to an MD's office or Hospital*****

☐ **Mail** ☐ **Pick-up** ☐ **Release to MD office/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:_____