Santa Monica Women's Health

OBSTETRICS, GYNECOLOGY AND FERTILITY

AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH INFORMATION

I authorize my medical records be released FROM: ____
Physician / Healthcare Facility

____
Address

________________________________ ________________________________
Phone Number Fax Number

I authorize my medical records be released TO: ____
Recipient

____
Address

________________________________ ________________________________
Phone Number Fax Number

Reason for Request:

□ 2nd Opinion □ Transferring Care □ Moving □ Insurance □ Other ____________________________

Please check all that apply

_____ Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis / treatment)

_____ Limited to the following medical information: ____

_____ Drug/Alcohol / Substance Abuse _____________ (initial) _____ Test for Antibodies to HIV _____________ (initial)

_____ Psychiatric / Mental Health _____________ (initial) _____ HIV Diagnosis / Treatment ____________ (initial)

________________ ______________________________ ________________
Date Patient's Name (Print) Date of Birth

________________________________ ________________________________
Signature of Patient or Legal / Personal Representative Relationship to Patient

________________________________ ________________________________
Witness Name Witness Signature