

# 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:

2<sup>nd</sup> 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

Santa Monica: 2001 SANTA MONICA BLVD., SUITE 970-W, SANTA MONICA, CA 90404    PHONE (310) 829-7878    FAX (310) 453-5586

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