<u>Authorization For Release of Medical Records</u>

PLEASE PRINT AND FILL OUT COMPLETELY

Women's Health Care
In San Diego, A.M.C.
3750 Convoy St #312
San Diego, Ca 92111
Ph# (858) 292-7200
Main Fax# (858) 505-0304

I, ___________________________________ Do Hereby Authorize Release Of My Records From
Dr:____
Address: ____
City, State, and Zip Code: ____
Doctors office Ph#___________________________ Fax#____________________________

Date of birth: __________________ SSN#_______________________________________
Other names used____
The last time I was seen in your office____
Patient day time ph #____

Reason for Release: ____Transfer of Care ___Consultation ___Copy for PCP ___Other
Release:
_____ All Medical Records _____ Radiology _____ Other ____ Pre-natal
_____ Lab Reports _____ Other _____ Operative Reports

Please send my records to:
Name: ____
Address: ____
City, State, and Zip Code: ____
Phone# ( )______________________Fax# ( )_______________________________

DURATION: I understand this authorization may be revoked in writing at any time, according to the instructions in the Women's Health Care in San Diego, A.M.C. Notice of Privacy Practices, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six months from the date of its authorization.

I hereby release Women's Health Care in San Diego A.M.C. from any/all legal liability that may arise from the release of this information to the party named above.

Patient Signature: ____________________________ Date: __________________________
*****Note if the patient is a minor, parent or legal guardian must sign below
Parent/Guardian ______________________ Date: __________________________________
*******Note in the event that the patient transfers care to a new physician, and requests Records release, these records will also be transferred unless indicated below. *******
_________________ Do not forward these records. I prefer to be contacted directly.