

Authorization For Release of Medical Records

PLEASE PRINT AND FILL OUT COMPLETELY

Women's Health Care

At Frost Street, A.M.C.

8010 Frost St. #301

San Diego, Ca 92123

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 at Frost Street, 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 at Frost Street, 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.**