

WOMEN'S SPECIALTY & FERTILITY CENTER
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient (List other names used)

Date of Birth

Please REQUEST Medical Information FROM:

Please SEND Medical Information TO:

Name of CURRENT RECORD HOLDER

Women's Specialty & Fertility Center

Street Address

729 N. Medical Center Dr W Ste 205

City, State, Zip Code

Clovis, Ca 93611

Telephone No. / Fax No.

Ph: (559)299-7700 Fx: (559)297-9679

I authorize the release and/or disclosure of my medical records/protected health information as requested above:
for the purpose of Ongoing Medical Care Third Party Payors Review Personal Review Other: _____

INFORMATION TO BE DISCLOSED: This authorization includes any and all health information except as specifically provided (e.g. HIV results, mental illness, substance abuse): _____.

DURATION: This authorization shall become effective immediately and shall remain in effect for one year or until _____.

REVOCACTION: This authorization may be revoked in writing by myself and will be revoked effective the date notified except to the extent action has already been taken.

AUTHORIZED USE/RE-DISCLOSURE: This signed authorization does not permit further disclosure of enclosed health information other than for its initial intended use, unless specifically required or permitted by law.

COPY: A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

Signature of Patient or Legal Representative

Date

Records Release Authorized By

Date

Records Sent By

Date