

**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:**

**Women's Specialty & Fertility Center**

\_\_\_\_\_  
Name of Entity to RECEIVE INFORMATION

**729 N. Medical Center Dr W Ste 205**

\_\_\_\_\_  
Street Address

**Clovis, Ca 93611**

\_\_\_\_\_  
City, State, Zip Code

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

\_\_\_\_\_  
Telephone No. / Fax No.

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 \_\_\_\_\_.

**REVOCATION:** 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