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:

Women's Specialty & Fertility Center

729 N. Medical Center Dr W Ste 205

Clovis, Ca 93611

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

Please SEND Medical Information TO:

_____

Name of Entity to RECEIVE INFORMATION

_____

Street Address

_____

City, State, Zip Code

_____

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