Fair Oaks Women's Health
Specialists in Obstetrics & Gynecology
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

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www.pasadenapregnancy.com
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

CHOOSE ONE OPTION BELOW: ☐ **Release to Me**

_____ **RELEASE**. Records to be **sent from Fair Oaks Women's Health to another provider.**

_____ **RECEIVE**. Have **another provider send my medical records to Fair Oaks Women's Health**.

1. Patient Information

_____

Patient Name *Date of Birth*

_____

Street Address *City* *State* *Zip*

_____

Phone *e-mail* *Fax*

2. PROVIDER

_____

Name of MD or Medical Facility *Address* *City* *State* *Zip*

_____

Phone *Fax*

3. Purpose of Request: _____

☐ Check here if you would like records sent digitally: If records are from us, we can provide a USB drive – needs to be picked up.

4. Authorization

I hereby authorize Fair Oaks Women's Health or the above Provider to release or receive information regarding my medical history, illnesses or injuries; consultations, prescriptions, treatments, diagnoses or prognoses; including images, correspondence and/or medical records; by means of mail, fax or other electronic methods.

I authorize the release of the information specified below (if left blank, then ALL INFORMATION will be selected)

- ☐ My health information related to genetics tests and results.
- ☐ My health information related to drug/alcohol/substance abuse.
- ☐ My health information related to psychological/psychiatric/mental health.
- ☐ My health information related to HIV/STD diagnosis and/or treatment.
- ☐ My health information related to the following treatment or conditions:

  _____

- ☐ **All my health information EXCEPT genetic tests, substance use, mental health, and STD's**
- ☐ **All my health information INCLUDING genetic tests, substance use, mental health, STD's**

5. Duration: This authorization is effective immediately and will remain in effect until _____
Date

6. Restrictions

Permissions for further use or disclose of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A copy of this authorization shall be considered as effective and valid as the original.

_____

Signature of Patient *(or legal representative)* Patient name (print) Date

_____

Witness signature Witness name (print) Date