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

www.fowh.com
www.pasadenapregnancy.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This authorization allows the release of confidential 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. TO: Healthcare Provider or Facility

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

_____
Phone *Fax*

3. Purpose of Records/Medical Information Release: _____

4. Please RELEASE my medical information to:

Fair Oaks Women's Health
625 S. Fair Oaks Ave., Suite 255, Pasadena, CA 91105
Phone: 626-304-2626 Fax: 626-585-0695 e-mail: obgyn@fowh.com

5. Authorization

I hereby authorize the above healthcare provider or facility to release 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:

- ☐ My health information related to genetics tests and results
- ☐ My health information related to drug/alcohol/substance use and/or abuse.
- ☐ My health information related to psychological/psychiatric/mental health.
- ☐ My health information related to HIV/AIDS/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**

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

7. 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 photocopy of facsimile 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