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

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This authorization allows Fair Oaks Women's Health to release confidential medical records.

1. Patient Information

_____

Patient Name *Date of Birth*

_____

Street Address *City* *State* *Zip*

_____

Phone *e-mail* *Fax*

2. Please RELEASE my medical information to:

_____

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

_____

Phone *Fax*

3. Purpose of Records Release: _____

4. Authorization

I hereby authorize Fair Oaks Women's Health 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 drug/alcohol/substance 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 including substance abuse, mental health and HIV/AIDS/STD related.

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 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

Note: There is a $30 fee for this service intended to cover the costs of supplies and employee time spent