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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 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.

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