# OBSTETRICS & GYNECOLOGY MEDICAL GROUP OF VERDUGO HILLS

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A Professional Corporation


## Authorization for Release of Medical Information

(Where Medical Records are currently)

I hereby authorize: ______________________________________________

Name Phone Fax

______________________________________________

Address

______________________________________________

City State Zip

(Where Medical Records are to be sent)

To send my medical records/information to:

______________________________________________

Name Phone Fax

______________________________________________

Address

______________________________________________

City State Zip

Name of Patient ______________________________ DOB ______________

______________________________________________

Address City State Zip Telephone

**Initial to specify which type of information is to be disclosed**

| **All Medical Records** | X Ray Results | Other |
|---|---|---|
| __________ | __________ | __________ |
| Lab Records | Progress Notes | Consultation |
| __________ | __________ | __________ |

Specify if certain years only: From ______ to _____, specify any exclusion __________.

Duration: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance to this authorization. Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Patient or Authorized Representative:

Signature:______________________________ Date: ______________

If not the patient, state relationship, print name and sign: ______________________________


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