Ventura County Obstetric and Gynecologic Medical Group, Inc.
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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please **REQUEST** Medical Information **From**:

_____
Name of Health Care Provider

_____
Name of Medical Office / Hospital

_____
Street Address

_____
City, State and Zip Code

Please **SEND** Medical Information **To**:

_____
Name of Person or Entity to Receive Information

_____
Title (Physician, Therapist, Attorney)

_____
Street Address

_____
City, State, and Zip Code

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.
Release and/or disclose records and information regarding:

_____
Name of Patient (List Other Names Used) Date of Birth

_____
Address City State Zip Code Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law. However, once your information is disclosed outside Ventura County Obstetric and Gynecologic Medical Group, Inc., it may not be protected.

Check the box and initial which type of information is to be released and/or disclosed:

SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:

☐ General Medical Information (from _____ to _____). General Medical Records may include references or referrals to mental health treatment, if noted by my provider, but not the mental health records themselves, unless specifically requested below.

☐ Information regarding specific injury or treatment (from _____ to _____)

☐ X-ray / Ultrasound Reports ☐ Operative / Discharge / ER Records

☐ Laboratory / Pap Smear / Pathology Reports ☐ Other: _____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only: _____

_____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep.

_____
Date Signature of Patient or Patient's Representative Indicate Relationship (if signed by other than patient)