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

_____
Phone # Fax #

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

_____
Name of Person or Entity to Receive Information

_____
Title (Physician, Therapist, Attorney)

_____
Street Address

_____
City, State, and Zip Code

_____
Phone # Fax #

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

Please send records from the following date range: _____

☐ Labs/ Radiology Reports ☐ History and Physical ☐ Consultation Notes
☐ Progress Notes ☐ Other: _____

Purpose of requested disclosure: _____

I specifically authorize release of the following information (check and initial as appropriate):

☐ Mental health treatment information _____ Initial if requesting
☐ HIV test results _____ Initial if requesting
☐ Alcohol/drug treatment information _____ Initial if requesting

*If **not** checked and initialed, the records containing such information **CANNOT** be released.

Duration: This authorization expires (insert date): _____
If no date is given, this authorization will expire six months from the signature date.

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to Ventura County Ob/Gyn Medical Group, Inc. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Re-disclosure: Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality lab (HIPAA).

Conditioning: I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

Fee for records: We may charge a fee of up to $25.00 for the release of records. There is no fee to release records to another doctor or medical facility.

This authorization is being requested of you to comply with the terms of Confidentiality of the Medical Information Act of 1981, Civic Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Patient Signature: _____ Date: _____

Legal Representative Signature: _____ Relationship to Patient: _____