Urogynecology Center of San Francisco
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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Phone: (415) 395-9895 Fax: (415) 395-9897 www.urogyncentersf.com

Patient Name: _____ Date of Birth: _____/ _____/ _____

Information to be released FROM:

☐ Urogynecology Center of S.F. or
☐ _____
Organization/Provider

_____
Street Address City, State, Zip

_____
Phone Fax

Information to be released TO:

☐ Urogynecology Center of S.F. or
☐ _____
Organization/Provider

_____
Street Address City, State, Zip

_____
Phone Fax

Information to be Released

Dates of service for records requested:
Beginning: _____
Thru: _____

☐ ALL RECORDS
☐ Clinical Notes
☐ Lab/Pathology Reports
☐ Radiology Reports
☐ Operative Reports
☐ Other (please specify) _____

Purpose of Release

☐ Copy for own use
☐ Transfer of Care
☐ Legal/Insurance

COPY FEES:
$25.00 – over 10 pages
$40.00 - Legal/Insurance
Please allow 7-10 business days for receipt of records.

Authorization for General Release of Information

I understand that:

- By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed above.

This authorization will expire **90-days** from the date signed below.
Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following:

☐ HIV/STDs
☐ Genetic Testing
☐ Pregnancy
☐ Mental Health

Signature of Patient or Legal Representative

_____ _____ _____
Date Signature of Patient/Legal Representative Relationship to the Patient

Signature of Minor Patient Required for the Following Records

Minor: A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy-related services (any age); 2) STDs, including HIV/AIDS (age 12 and older); 3) Substance abuse and mental health treatment (age 12 and older).

_____ _____ _____
Date Signature of Minor Patient Print Name