

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

Information to be released TO:

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

Street Address City, State, Zip

Phone Fax

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