Partnership for Women's Health

Obstetrics, Gynecology, and Infertility
Lauren Hyman, MD, FACOG   Imelda Tio, MD, FACOG
7320 Woodlake Avenue Suite 280, West Hills, CA 91307
Phone (818) 932-0728 Fax (818) 932-9037

Authorization for Medical Records Release

Patient's Name ____ Date of Birth ____/____/____

Treatment Dates ____

Information to be released from:

Physician/Medical Group ____

Street Address ____

City ____ State _______ Zip _______________

Phone Number (_____-______-______)   Fax Number (_____-______-______)

Information to be released:

____ Hospital/Operative Reports
____ History & Physical Exam
____ Progress Notes
____ Other (Specify) _______________________
____ Lab/Radiology reports
____ Medication reports
____ ALL MEDICAL RECORDS

This authorization is effective immediately and is subject to revocation at any time. The authorization expires 90 days from the date of signing. If it has been more than 3 years since you have been seen in our office, a $25 service fee will be assessed to retrieve the file from our storage facility.

I understand that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign.

In addition to the above records, I consent to the release of records including those of:

Drug/Alcohol/Substance Abuse __________ (initial)
Psychiatric/Mental Health __________ (initial)
Test for Antibodies to HIV __________ (initial)
AIDS diagnosis/Treatment __________ (initial)

I further release my attending physician, consultants, the facility, and employees from any liability arising from the release of information to the person(s)/agency designated above.

I understand that I have the right to receive a copy of this authorization upon my request.

Signature of Patient ____ Date_____/_____/_____

Signature of Parent/Guardian ______________________________________ Date_____/_____/_____