OBSTETRICS - GYNECOLOGY - INFERTILITY
15151 NATIONAL AVENUE - LOS GATOS, CA 95032 - PHONE:(408) 356-0431 - FAX (408) 356-8569
www.lowmg.com

## AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION TO LOS OLIVOS

Patient Name _____ Acct. No. _____

Former Name (if any) _____ SS # _____

Daytime Telephone _____ Birthdate ____/_____/____

INFORMATION TO BE RELEASED FROM:
I hereby authorize (Name of Organization): _____
to release the following medical information contained in the patient's medical record:

Address:_____
Street City State Zip

**INFORMATION TO BE RELEASED TO:**

Los Olivos Women's Medical Group Attn: Dr._____
15151 National Avenue
Los Gatos, CA 95032

**TYPE OF INFORMATION TO BE RELEASED:**

1. GENERAL RELEASE:

____All Medical Records/Excluding Protected Records (incuding ultrasound, mammogram, pap smear, laboratory, operative and pathology reports) From_____ to_____

____Lab Results (specify)_____ From_____ to_____

____Ultrasound Reports (specify)_____ From_____ to_____

____Pathology Reports (specify) _____ From_____ to _____

____Operative records (specify)_____ From_____ to_____

____Other Records (specify)_____ From_____ to_____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

____Drug Abuse Diagnosis/Treatment From_____ to_____

____Alcoholism Diagnosis/Treatment From_____ to_____

____Mental Health Diagnosis/Treatment From_____ to_____

____Sexually Transmitted Disease Diagnosis/Treatment or Counseling (includes AIDS/HIV) From_____ to_____

**PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

_____ _____ _____

| Date | Signature of Patient /Legally Responsible Party | Relationship to Patient if not Patient |
| --- | --- | --- |