GOLDEN GATE
OBSTETRICS & GYNECOLOGY

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I authorize the release of my medical records: Name _____ DOB _____

Release Records From:

_____

_____

_____

Phone:_____Fax:_____

Send Records To:

_____

_____

_____

Phone:_____Fax:_____

☐ Medical Records from past **ONE** year
☐ Medical Records from past **FIVE** years
☐ Medical Records from **CURRENT PREGNANCY**

☐ Dates treated from _____ to _____
☐ Other (please describe)

Purpose for Disclosure:

☐ Leaving our care for remainder of current pregnancy
☐ Relocation
☐ Consult with another Physician
☐ Self

Delivery Preference:

(Please allow up to 5 business days to complete medical records request)

☐ Fax
☐ US Mail
☐ Email to patient via secure PDF (Password is your date of birth: MMDDYYYY)

Disclosure:

By signing below, I acknowledge that I have read and understand this authorization and I allow Golden Gate Obstetrics and Gynecology to release my records to the requestor named above. I also acknowledge that I am responsible for all fees that may occur due to my records request. This authorization will expire in 365 days from the date signed.

Signature: **Date:**