GOLDEN GATE
OBSTETRICS & GYNECOLOGY

1725 Montgomery Street, Suite 200
San Francisco, CA 94111
Phone (415) 666-1250 Fax (415) 398-2696

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name:_____ **Date of Birth**: _____

Release Records From:
Office : _____
Phone: _____
Fax/Email: _____

Send Records To:
Recipient Name: _____
Phone: _____
Fax/Email:_____

☐ Medical Records – All
☐ Medical Records from CURRENT PREGNANCY
☐ Other (please describe) _____

Purpose for Disclosure:

☐ Leaving our care* ☐ Consult with another Physician ☐ Self

Delivery Preference: *(Please allow up to 3-5 business days to complete medical records request)*

☐ Fax to another Physician – NO Fee Required
☐ Email to patient via secured PDF *(Password is patient's date of birth: MMDDYYYY)* – NO Fee Required

Disclosure:
**Leaving our care*- I understand that by withdrawing my care from Golden Gate OBGYN, I will no longer be able to receive medical advice from the practice.

By signing below, I authorize the release of my medical records to the office/provider named above. I 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. I acknowledge that I have read and understand this authorization.

Signature:_____ **Date:** _____