GOLDEN GATE
OBSTETRICS & GYNECOLOGY

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Phone (415) 666-1250 Fax (415) 398-2696

AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION

FULL NAME: DATE OF BIRTH:

RELEASE RECORDS FROM:	**SEND RECORDS TO:**
OFFICE:	OFFICE:
PHONE NUMBER:	PHONE:
FAX NUMBER:	FAX NUMBER:

☐ - ALL MEDICAL RECORDS
☐ - CURRENT PREGNANCY RECORDS
☐ - OTHER (please describe) _____

PLEASE PLACE YOUR INITIALS BESIDE THE OPTION BELOW TO AUTHORIZE THE RELEASE OF SENSITIVE INFORMATION PERTAINING TO:

DRUGS/ALCOHOL _____ MENTAL HEALTH _____ HIV/AIDS/OTHER INFECTIOUS DISEASES _____

GENETIC TESTING _____ NOT APPLICABLE _____

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)* – ($0.25 per page)

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:** _____