AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Social Security #: _____

Patient Phone #: _____

I request and authorize: _____

_____

to release healthcare information of the patient named above to:

Valley OBGYN Medical Group Inc.
1600 East Florida Avenue, Suite 315
Hemet, CA 92544

Phone: 951-765-1766
Fax: 951-750-5089

This request and authorization applies to:

☐ All healthcare information

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Other: _____

Signature: _____ Date Signed: _____
Patient/Legal Representative

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.