

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: _____
Patient/Legal Representative

Date Signed: _____