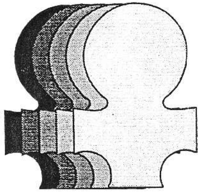

PASADENA WOMEN'S MEDICAL GROUP, INC.

50 Alessandro Place, Suite 430 Pasadena, CA 91105 • (626) 796-9114

Record Release Authorization

Date: ______________________________

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Information and records regarding treatment of minors, HIV, psychiatric/ mental health conditions, or alcohol/substance abuse have special rules that apply and require specific authorization.

I hereby authorize: ____

____

____

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, correspondence and /or medical records by means of mail, fax or other electronic methods.

To: ____

____

____

- **Reason for record request:** ____

This authorization will automatically expire six months from the date of execution unless otherwise noted here: __________

This authorization is for:

- ☐ All Ob/Gyn Related Records (INCLUDING HIV test results) ________ ⬅ initial here
- ☐ All Ob/Gyn Related Records (NOT INCLUDING HIV test results)

Limited to the following medical information (only):

- ☐ Pap Smears
- ☐ Genital Cultures
- ☐ Pelvic Ultrasounds
- ☐ Mammogram
- ☐ Bloodwork
- ☐ Sexually Transmitted Disease Tests
- ☐ Pregnancy Records

Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically requested or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

Patient's Name (Printed): ____

Other Relevant / Former Names: ____

Date Of Birth: ____

Social Security Number: ____

Signature: ____

Fax: (626) 796-8523 e-mail: pwmg@earthlink.net