**Women’s OB/GYN**

**Lela Emad, MD, FACOG Susan Logan, MD, FACOG**

**1111 SONOMA AVENUE, Ste 202 SANTA ROSA, CA. 95405**

**(707) 575-1626 fax: (707) 575-3941**

## **RECORDS RELEASE AUTHORITY**

## **To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## **I hereby authorize and request you to release to Women’s OB/GYN my complete medical records in your possession concerning my treatment to include any and all history notes, progress notes, operative reports, lab/x-ray reports, physical exam notes and all other medical records. The records should be sent directly to:**

Women’s OB/GYN

1111 Sonoma Ave., Ste. 202

Santa Rosa, CA 95405

**Reason: For physician consultation and continued care.**

**This authorization is valid for ninety (90) days from the date of my signature below. A copy of this authorization form shall be deemed as valid as an original. This authorization may be revoked in writing at any time. My written revocation will be effective upon receipt but will not be effective to the extent that Women’s OB/Gyn or others have acted in reliance upon this authorization. I understand that I may request a copy of this signed authorization.**

#

**Patient Name (Print clearly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Names Used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approximate Date of Last Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_***

**Relationship to the Patient*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***