WOMEN'S CLINIC
COUNSELING CENTER

Women's Clinic and Family Counseling Center
11500 West Olympic Blvd, Ste 422
Los Angeles, CA 90064

Telephone:
310 479-7100

Fax: 310 479-7144

Release of Medical Information

(AUTHORIZATION FOR RELEASE OF (PHI) PROTECTED HEALTH INFORMATION)

Please PRINT

PATIENT NAME_____ DATE OF BIRTH_____

STREET ADDRESS_____

CITY, STATE, ZIP_____

HOME PHONE _____ CELL PHONE_____FAX _____

I, (Print Name)_____, do hereby grant authorization to Women's Clinic to release all medical records (PHI) to the following person/facility:

Name of person/facility to receive PHI: _____

Address _____

City, State, Zip _____

Medical Records are to be released via: (check appropriate line)

___ Presented to me in person ___ Fax (include fax number)

___ Mail (include mailing address, if not your own) _____

_____

_____

(**Option for sending records via email is <u>not</u> available**)

The Purpose of this Release Is (check one or more:)

- ☐ At the request of the patient/patient representative
- ☐ Other (state reason) _____

Initials of Patient or Legal Representative: _____

NOTICE Women's Clinic and other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

_____ _____

Signature of Patient Signature of Medical Records Personnel

_____ _____

Date Date Sent

LAST REVISED 11/20/2017