AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I Authorize: ____
(**Name of person or facility where prior care given**)

____
(**Street Address, City, State, Zip Code**)

From: **Name**: ____

DOB: ____

I have previously received care at your facility. I authorize you at my own request to release my medical records for the purpose of continuity of my health care. Please promptly provide to my doctor at the address below the information as listed below. This authorization is completely voluntary. This authorization may be revoked at any time (supplied in writing to addressee). I have kept a copy of this authorization. Unless otherwise revoked, this authorization will expire one year after the date of signature.

- a summary of pertinent OB/Gyn related notes that may include (**initial lines**:
  _______ HIV test results (Health & Safety Code 120980(g)).
  _______ Genetic testing information (Health & Safety Code 124980(j))
- a copy of my most recent pap smear report
- a copy of my most recent mammogram report
- a copy of my most recent pelvic ultrasound report (if available)
- a copy of my most recent <u>complete gynecologic visit</u>
- a copy of a summary of OB care for each pregnancy (as available)

Please release this health information by mailing it to:

Dr. Ruth Haskins
1611 Creekside Drive Suite 103
Folsom, CA 95630

Print Name: ____

Signed: ____

Date: __________________________ **Time:** ______________