Authorization for Disclosure of Patient Health Information

Patient's name: _____ Date of Birth: _____

Address: _____

Telephone: _____

I authorize: (person or facility which has health information)	**To release health information to:** (person or facility to receive health information)
Name: Women's Group for Health	Name: _____
Address: 2999 Regent St., Ste 201	Address: _____
Berkeley, CA 94705	_____
Phone: (510) 204-0965 Fax: (510) 549-0334	Phone: _____ Fax: _____
Email: n/a	Email: _____

Authorization includes ALL medical records unless otherwise specified below:

- _____
- _____
- _____
- _____

-If the patient is requesting medical records to be faxed, Women's Group for Health is not responsible for confidentiality. _____ INITIALS

-I have been informed of Women's Group for Health payment policy. _____ INITIALS

……
Patient/Guardian Signature Date

……
Print Name