



15151 NATIONAL AVENUE - LOS GATOS, CALIFORNIA 95032
Phone: (408) 356-0431 - FAX: (408) 356-8569
www.lowmg.com

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION TO LOS OLIVOS

Patient Name _____ Acct. No. _____
Former Name _____ SS # _____
(if any) _____
Daytime _____ Birthdate ____/____/____
Telephone _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize (Name of Organization): _____
to release the following medical information contained in the patient's medical record:

Address: _____
Street City State Zip

INFORMATION TO BE RELEASED TO:

Los Olivos Women's Medical Group Attn: Dr. _____
15151 National Avenue
Los Gatos, CA 95032

TYPE OF INFORMATION TO BE RELEASED:

1. GENERAL RELEASE:

____ All Medical Records/Excluding Protected Records (including ultrasound, mammogram, pap smear, laboratory – this will be limited to the most recent two years of information unless otherwise stated) From _____ to _____
____ Lab Results (specify) _____ From _____ to _____
____ Ultrasound Reports (specify) _____ From _____ to _____
____ Pathology Reports (specify) _____ From _____ to _____
____ Operative records (specify) _____ From _____ to _____
____ Other Records (specify) _____ From _____ to _____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

____ Drug Abuse Diagnosis/Treatment From _____ to _____
____ Alcoholism Diagnosis/Treatment From _____ to _____
____ Mental Health Diagnosis/Treatment From _____ to _____
____ Sexually Transmitted Disease Diagnosis/Treatment or Counseling From _____ to _____
(includes AIDS/HIV)

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date Signature of Patient /Legally Responsible Party Relationship to Patient if not Patient