LOS OLIVOS
WOMEN'S MEDICAL GROUP

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 (if any) _____ SS # _____

Daytime Telephone _____ Birthdate ____/_____/____

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 (incuding 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 (includes AIDS/HIV) From_____ to_____

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____ _____

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