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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

**Sensitive information:** I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV), It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

**Redisclosure:** I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by the federal confidentiality rules.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based in this authorization.

**Other Rights: (a)** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. **(b)** I understand that I may inspect or obtain a copy of the information to be used to disclosed.

**Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ( If I do not specify an expiration date, event, or condition, this authorization will expire in six months)**

Patient Signature  
(or legal  
representative): \_\_\_\_\_ Date Signed: \_\_\_\_\_

If signed by legal representative, relationship to patient: \_\_\_\_\_

### Administration Fees:

**Patient Fee \$30.00**

**Insurance and Legal Firms \$50.00**