769 Medical Center Court, Suite 301 Chula Vista, Ca 91911

Office (619)271-2700

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ **DOB:**_____

Phone Number:_____

Address: _____

The above listed patient authorizes *Kamali OB-GYN* to **receive** any and all medical records from _____

Purpose of disclosure:

___ Change of insurance or physician ___ Referral

___ Continuation of care ___ Other

This authorization is vaild only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information related to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I may revoke this authorization at any time and if I do, I must do so in writing. Revocation will not apply to information that has already been released.

This authorization will expire one year for the date signed.

I have read the above authorization and release information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature_____ **Date**_____

Please send records to FAX (619) 737-9387