Plaza-Towers Obstetrics and Gynecology
Medical Records Department
2001 Santa Monica Blvd Suite 468W
Santa Monica , CA 90404
Tel. 310-255-0990 Fax 310-255-0996

AUTHORIZATION
For The Release of Medical Information

Patient Name: _____Phone Number:_____
Patient Address:_____
Medical Record #:_____Date of Birth: _____ /_____/_____
MM DD YYYY
Social Security Number: _____ - _____- _____

"I hereby authorize Plaza-Towers Ob/Gyn to make uses and disclosure of my protected health information (information pertaining to my medical records and/or financial records) as indicated below."

THIS INFORMATION IS TO BE DISCLOSED TO:

Name: _____ Attention:_____

Street Address: _____

City/State/Zip Code: _____

Phone No: _____ Fax No: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____
_____

For dates of treatment from _____to _____

REASON FOR REQUESTED USE OR DISCLOSURE:

☐ Transfer of health coverage ☐ Personal Use ☐ Form Completion ☐Referral ☐Change in health care provider
☐ Other reason _____

This authorization expires in 6 months from the date signed or earlier _____.
DATE

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure from any individual to do so.
e. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
g. I will receive a copy of this completed and signed authorization form.

Medical Records Copying Fees: $25

Patient Signature _____ Date _____

Signature of Patient's Representative_____Relationship_____Date_____

Office Use Only: Initials _____ Date Faxed/Mailed/Copied_____