BAY AREA MATERNITY
& WOMEN'S HEALTH

RELEASE OF MEDICAL INFORMATION

I hereby authorize:

____
Recipient/Doctor/Hospital Name

____
Address

____
City State Zip

____
Phone Fax

To disclose to:

Bay Area Maternity & Women's Health
Lin Lee, CNM
Maria Greulich, CNM

777 Knowles Drive, Suite#11,
Los Gatos, CA 95032-1425
Tel (408) 883-8233 Fax (408) 883-8211
www.bayareamaternity.com

__________________________________ __________________
Name of Patient Date of Birth

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _______________(date).

Revocation: This authorization is also subject to written revocation by the member/patient at any time.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

By initializing, I authorize the release of the following information:

_____ Progress Notes ______Lab tests/Pap smear Results ______Operative Reports
_____ COMPLETE Prenatal Records including labs and ultrasound reports
_____ Mammography Reports _____Other (please specify)________________________
_____ ALL RECORDS (Last 3 Years, but include all previous pregnancies if any)

COMMENTS: ____

A copy of this authorization is valid as the original.

____________________________________ __________________ ____________
Signature Relationship to patient Date