AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name _____ DOB _____

Address _____

City _____ Zip Code _____ Phone # _____

I request and/or authorize: Specialty Obstetrics of San Diego

3750 Convoy St., Ste. 200

San Diego, CA 92111

Phone: (858) 794-7700 Fax: (858) 794-7744

To release the following medical records: _____

_____

From Date ___ / ___ / ___ To Date ___ / ___ / ___

To be released to: _____

Address _____

City _____ Zip Code _____

Phone # _____ Fax # _____

Reason for request _____

Patient / Guardian Signature Date of Request

Only the information you have requested will be released or received. You have the right to revoke this authorization at any time by submitting a written notice to the Front Office Receptionist.