Authorization for Release of Medical Records

I hereby authorize the release of my medical or copies of same from:

Aptos Women's Health
3275 Aptos Rancho Rd. Suite E
Aptos, CA 95003
Fax: 831-688-0811
Phone: 831-688-8266

To:______________________________
Doctor, Hospital, or Self
Address:_________________________
____
Phone:__________________________
Fax:_____________________________

Of my Medical records, please Provide:

- ☐ Medical overview: Medical Health Summary along with records since Dec 2012 (complimentary if sent to a medical provider, $20 charge for patient pick-up)
- ☐ My archived paper chart, after it has been scanned into Epic. (complimentary, will be available for office pick-up first week of October)
- ☐ Only The following portion of my medical records: ____

I agree to pay a reasonable cost to cover this service.

Signature:___________________________________ Date:_____________
Patient name:____
Other names records might be under:_______________________________________
Address:____
Phone #:(___)____-______
Date of Birth:____/____/____
Social security#:____-___-_____