

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

Patient's Name: _____ Date of Birth: _____

AKA: _____ SSN: _____

Home Telephone #: _____ Medical Record #: _____

Authorization	<p>I hereby authorize/request that _____ to disclose (Name of Hospital/Physician)</p> <p>information to:</p> <p style="text-align: center;">Sacramento Maternal Fetal Medicine Medical Group, Inc. 5301 F Street, Suite 110 Sacramento, CA 95819 Phone (916) 733-1900 Fax: (916) 733-7153</p>
Information	<p>Type of Access Requested: <input type="checkbox"/> Copies <input type="checkbox"/> Inspection</p> <p>Dates of Treatment: _____</p> <p>Information to be Released: _____</p> <p>Purpose for Disclosing Information: _____</p>
Signature	<p>_____ Date of Signature _____ Patient Signature (Patient/Legal Representative)</p> <p>_____ Relationship (if signed by other than patient)</p>
Release of Alcohol/Drug/Psych Information	<p>I also consent to the release of any and all alcohol and/or drug abuse and psychiatric treatment records under the same conditions as outlined above. I understand that such information cannot be released without my specific consent.</p> <p>_____ Date of Signature _____ Patient Signature (Patient/Legal Representative)</p> <p>_____ Relationship (if signed by other than patient)</p>

Unless otherwise specified, this authorization shall expire in six (6) months. I understand I have the right to receive a copy of this authorization upon my request.

Telephone: (916) 733-1900
Fax: (916) 733-1753