PACIFIC GYNECOLOGY AND OBSTETRICS
MEDICAL GROUP
2100 Webster Street, Suite 319
San Francisco, CA 94115
(415) 923-3123 office (415) 923-3132 fax

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT: _____ DOB: _____

ADDRESS: _____ PHONE: _____

_____ Morey Filler, MD

_____ Julie J. Huh, MD

_____ Bonni S. Massa, MD

_____ Jean M. Yu, MD

_____ Katerina R. Lyons, PA-C

_____ Cindy A. Grijalva, MD

_____ Leslie S. Kardos, MD

_____ Rebecca Yee, MD

_____ Olga Hidchenko, NP-C

I, the undersigned, hereby authorize the above mentioned health practice facility to provide medical information from the above named patient's medical records to the physician mentioned below:

TO: _____

_____

_____

I realize I have the right to a copy of this authorization. This authorization should be valid for one year after the date below.

SIGNATURE: _____ DATE: _____

OR: _____
Patient's legal representative if patient is under 18 years old or unable to sign (state reason).

$25 Fee for Medical Records.
Please allow 7-10 business days for receipt of records.