PACIFIC GYNECOLOGY AND OBSTRETICS 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

____Bonni S. Massa, MD

____Jean M. Yu MD

___ Alaina Pirie NP

__ Karlee Johnson PA

____ Julie J. Huh, MD

____ Rebecca Yee, MD

____ Cindy A. Grijalva, MD

____ Teresa Safer, MD

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 BUSSINESS DAYS OF RECEIPT OF RECORDS.