FOLSOM OB/GYN

FOLSOM OBSTETRICS & GYNECOLOGY MEDICAL GROUP, INC.
1735 CREEKSIDE DRIVE
FOLSOM, CA 95630
PHONE: 916-983-3500 FAX: 916-983-8437

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____/_____/_____
Home Address: _____
City _____ State _____ ZIP _____
Telephone Number: (____)_____-_____ Cell phone (____)_____-_____

SEND MEDICAL RECORDS
☐TO ☐FROM

Jeffrey R. Cragun, M.D., Carrie A. Gordon, M.D.,
Stacie Thum, MSN, FNP-C, Emily O'Neal, PA-C, MSPAS

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SEND MEDICAL RECORDS
☐TO ☐FROM

Physician/Clinic: _____

_____
Address City State Zip Code

(_____)_____-_____ (_____)_____-_____
Telephone Fax

INFORMATION REQUESTED:

☐ **ALL RECORDS**
☐ RECORDS FOR DATES– from: _____ to: _____
☐ OTHER (be specific)
PURPOSE OF DISCLOSURE: _____

This authorization is valid for 90 days from the date set forth below opposite my signature and may be revoked at any time in written prior to the expiration of such 90 day period. Revocation of this authorization shall not affect releases made prior to the revocation.

I understand that authorizing the disclosure of my protected health information is voluntary and that I need not sign this authorization in order to assure medical treatment. I further understand that the disclosure of this information carries with it the potential for unauthorized redisclosure and the information may no longer be protected by federal confidentiality rules.

I certify that I have the authority to approve this requested release and to sign this authorization.

_____ _____
Patient Signature (or legal representative) Date

ALL REQUESTS WILL REQUIRE 7-10 BUSINESS DAYS FOR COMPLETION