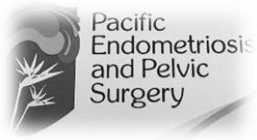

Authorization to Release Medical Records

(Please Print)
Name: _____DOB: __/___/___ PHONE #: (____)_____-_____

Address: _____
Street City State Zip

I hereby authorize PACIFIC ENDOMETRIOSIS AND PELVIC SURGERY to release protected health information, including copies of the medical record of the above-named patient, to the following person or facility: Recipient/Facility's

(Please Print)

Name: _____PHONE #: (____)_____-_____ Fax #: (____)_____-_____

Address: _____
Street City State Zip

I understand that I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at PACIFIC ENDO(a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required. I may revoke this authorization at any time by submitting a written notice of revocation to PACIFIC ENDO at the address listed above. The revocation will be effective upon PACIFIC ENDO receipt of my written notice, except that it will not have any effect on any action already taken by PACIFIC ENDO in reliance on this authorization. Once PACIFIC ENDO has disclosed my health information to the recipient, PACIFIC ENDO cannot guarantee that the recipient will not disclose my health information to a third party. This authorization will automatically expire 90 days from the date set forth below.

Please circle the purpose of release: Continuing Care Copies for own use Insurance Legal Other

Please initial by the item(s) you would like sent:

_____ All medical records _____Specific Chart notes (Please describe below under additional info) _____LABS/IMAGING

_____Operative reports _____ Procedure notes _____Other/Specific dates From: ___/___/___ Through: ___/___/___

DATES TO BE RELEASED: ☐ Most recent two years ☐ Most recent five years ☐ All dates ☐ Specific Dates

This authorization will expire when request has been fulfilled or on this date: ____/_____/_____

ADDITIONAL INFORMATION REGARDING YOUR REQUEST: (PLEASE USE THE LINE BELOW)

_____

The following categories of information may be included in your medical record Abortion, Genetic Testing, Alcohol/Drug Abuse, HIV/AIDS Results/Treatment, Behavioral Health, Rape/Sexual Assault, Domestic Violence, Sexually Transmitted Diseases and other sensitive information you may have disclosed. I acknowledge that there may be a Medical records handling fee required prior to processing this medical records request. You will be notified by Pacific Endometriosis staff if any fees apply.

REVIEW AND SIGNATURE

By signing this page, I acknowledge that I have read and agreed to the terms on this form.

_____ ____/____/____ ____:____ am/pm

Signature of patient or person authorized to give authorization **Date** **Time**

If signed by person other than patient, provide reason, relationship to patient & description of authority

_____