PACIFIC COAST WOMEN'S HEALTH
MEDICAL RECORD RELEASE

PLEASE PRINT:

To: Pacific Coast Women's Health
317 N. El Camino Real, Suite #306
Encinitas, CA 92024
Phone: (760) 944-1000
Fax: (760) 944-1123

I,______________________________________
Name

____
Address

____
City State Zip Code

Request that you send a copy of my ________________________________to:

____
Name

____
Address

____
City State Zip Code

Phone# ________________Fax#_____________

This information is to be sent because:

- ☐ Notification to my primary care physician
- ☐Transferring Medical Care
- ☐Moving out of the Area
- ☐Other:______________________________

____
Patient/ Guardian signature Date of request

This authorization is effective until ___________________________.

_____ there is a fee for copying and mailing/faxing records.
Initials

Only the information you have requested will be sent. You have the right to revoke this authorization at any time by submitting a written notice to the secretary at the reception desk.

Request to be given to

☐Provider _________initials

☐Billing _________initials

☐Auth/Ref _________initials