REQUEST FOR RELEASE OF MEDICAL INFORMATION

TO:/FROM: _____

_____

I hereby authorize: _____

Address: _____

_____

_____

to release any and all records or a summary of findings and recommendations with particular reference to:

_____

_____

Please send for review the followingx-rays and/or slides. These will be returned to you as soon as possible.

_____

TO: / FROM

James E. Ramseur, Jr., M.D.
FELLOW AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY
900 Cass St. • Suite 101 • Monterey, California 93940
(831) 649-1144 • FAX (831) 649-3529

Patient's Name: _____

Former Name: _____

Birthdate: _____

Approximate date of care: _____

This authorization shall become effective immediately and shall expire six months from this date unless indicated otherwise or revoked earlier in writing. I understand that this information cannot be further released without my specific written consent. No further authorization is made than is specifically indicated herein. I further understand that I have a right to receive a copy of this authorization upon my request.

_____ _____

Patient, parent, guardian or legal representative signature Date

PATIENT: SIGN AND DATE ABOVE; THEN MAIL DIRECTLY TO THE LOCATION OF YOUR RECORDS.