Obstetrics / Gynecology
Fertility / Menopause
Laparoscopic Surgery

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RELEASE OF MEDICAL RECORDS

To: San Francisco Women's Healthcare, Inc.

I authorize and request the release of medical records concerning my examination, treatment, operative and laboratory reports regarding:

__OB/GYN records

__PAP Smear report only

__Complete medical records

__Other: _____

__for the dates of _____to_____

Please release records to: _____
Name

_____
Address

_____
City State Zip

_____ _____
Signature of Patient Date Signed

_____
Print name

_____
Birth Date

I consent to the release of the results of the HIV antibody test and any other HIV testing, diagnosis and treatment information protected by the Health and Safety code section 199.21.

_____
Signature of Patient

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