*Medical*

For Women By Women
Rosanne Mayhew, M.D.

Gynecology and Women's Health

PO Box 320693 Los Gatos, CA 95032
Phone 408.871.1885 Fax 408.871.8405

I hereby authorize/disclose my records to:________________________________________
(OTHER PHYSICIAN'S NAME)
Dr Rosanne Mayhew at PO Box 320693, Los Gatos, CA 95032

DURATION : This authorization shall become effective immediately and shall remain in effect until________________________or for one year from the date signature.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization .

RE-DISCLOSURE : II understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY: Check and initial to specify which type of information is to be disclosed

RECOR DS: MEDICAL INFORMATION __________
DRUG/ ALCOHOL INFORMATION ______
PSYCHIATRIC IN FORMATION _____
RESULTS OF AN HIV BLOOD TEST _____
OTHER HEALTH INFORMATION __________

SPECIFY THE RECORDS TO BE DISCLOSED:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

The requester may use the health information authorized on this form for the following purposes only:

______________________________________________________________________

______________________________________________________________________

DATE: ____________________ SIGNATURE: ________________________________________

NAMEOFPATIENT:________________________________________