California Center for
Reproductive Health

16550 Ventura Blvd., Suite 400, Encino, CA 91436

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT'S NAME: _____

PATIENT'S ADDRESS: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

I HEREBY AUTHORIZE THE ***CALIFORNIA CENTER FOR REPRODUCTIVE HEALTH*** TO MAKE USE AND/OR DISCLOSURE OF MY HEALTHCARE INFORMATION AS INDICATED BELOW:

RECEIVE MY MEDICAL RECORDS FROM:

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____

_____

_____

_____ _____

SIGNATURE OF PATIENT DATE