

**If you would like to be seen in our office and you have records at another office please complete the following and mail or fax it to your existing provider.**

**MEDICAL RECORD RELEASE FORM**

DATE: \_\_\_\_\_

**TO: OB-GYN WOMEN PHYSICIANS ASSOC. INC**  
**15195 National Avenue #207**  
**Los Gatos CA 95032**  
**408-358-1881 ph 408-356-9608 fx**

I hereby authorize you to release to:

Doctor \_\_\_\_\_

\_\_\_\_\_ FX# \_\_\_\_\_

any information including the diagnosis and records of any treatment or examination rendered to me during the period from \_\_\_\_\_ to \_\_\_\_\_

/\_/\_ I want my records faxed to the above doctor.

/\_/\_ I want my records mailed to the above doctor.

Signature \_\_\_\_\_ Name \_\_\_\_\_

Witness \_\_\_\_\_ DOB \_\_\_\_\_