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Vital Health
ENDOMETRIOSIS
CENTER

14830 Los Gatos Blvd., Suite 300
Los Gatos, CA 95032
Tel (408) 358-2511
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: _____

I, _____ HEREBY AUTHORIZE

_____
Name of Hospital / Physician / Facility

PHONE: _____ FAX: _____

TO RELEASE INFORMATION SPECIFIED BELOW FROM MY MEDICAL RECORDS COVERING

THE DATES OF SERVICE _____ TO _____

THE INFORMATION WHICH IS CHECKED (X) BELOW IS TO BE RELEASED TO:

Vital Health Institute
14830 Los Gatos Blvd., Suite 300
Los Gatos, CA 95032
Phone: 408-358-2511
Fax: 408-358-1009

CHECK OFF ITEMS BEING RELEASED

- ☐ **OPERATION AND PATHOLOGY REPORTS**
- ☐ **DIAGNOSTIC TESTS**
- ☐ **LABORATORY / X-RAY RESULTS, excluding HIV**
- ☐ **HISTORY AND PHYSICAL REPORTS**
- ☐
- ☐ **OTHER: __ _____**

AND REQUEST THAT THE CHECKED RECORDS BE FAXED NO LATER THAN _____

This authorization for release of medical records form is valid now and will remain in effect until _____. Furthermore, I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS:

Patient:_____ Date: _____