WOMEN'S WELLNESS & GYN SURGERY CENTER
Karen Leung, MD, FACOG

Authorization for Release of Medical Records

Patient Information (Please Print):

Name:_____ **Date of Birth:**_____

Address:_____

Phone:_____

RELEASE MY MEDICAL RECORDS FROM:

NAME:_____

TEL:_____

FAX:_____

TO

Karen Leung, M.D.
Women's Wellness and GYN Surgery Center
4655 Hoen Avenue, Suite 8
Santa Rosa, CA 95405

Phone: (707) 545-8881
Fax: (707) 545-8817

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results, and diagnostic tests.

_____ _____

Signature **Date**

REVOCATION

This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others who have acted in reliance upon this authorization.

EXPIRATION OF AUTHORIZATION

This authorization shall become effective immediately and shall remain in effect for one year of this signature date noted above.