

BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

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**AUTHORIZATION TO OBTAIN MEDICAL RECORDS**

This letter authorizes Bay Area Obstetrics & Gynecology, P.A. to obtain a copy, summary or narrative of my medical records, including any information about drug and alcohol screens or treatment, AIDS/HIV testing and/or diagnosis, and psychiatric or psychological testing and/or diagnosis concerning the treatment of myself covering the period from \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_  
Doctor's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

I, hereby release you, your physicians and employees from liability for following this authorization and request.

The reason or purpose to obtain my medical records is as follows:

\_\_\_\_\_.

**AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF SIGNATURE.**

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name      DOB

\_\_\_\_\_  
Address

obrecords

\_\_\_\_\_  
City, State, Zip Code