LAGUNA BEACH OBSTETRICS & GYNECOLOGY
31852 Pacific Coast Highway Suite #200
Laguna Beach, CA 92651
Telephone: 949-499-2258 Facsimile: 949-499-5697
Dr. Kenneth A. James

MEDICAL INFORMATION RELEASE

Full Name: ________________________________ Date Of Birth: ___________________________

I hereby request and authorize the release of medical information:

Medical information released by:

Name: ___________________________________

Address: ___________________________________

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Phone: ___________________________________

FAX: ___________________________________

Medical information released to:

Name: ___________________________________

Address: ___________________________________

____

Phone: ___________________________________

FAX: ___________________________________

Signature of Patient or Representative: _____ ____

Relationship to Patient: _______________________ Date: ____________________________________

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Records Requiring Specific Consent

Patient's Name (Print): _____________________________________

My initials and signature below authorize the release of healthcare information relating to testing, diagnosis and/or treatment for:

_____ HIV/AIDS _____ Sexually Transmitted Diseases _____ Mental Health

_____ Alcohol/Drug Abuse _____ Reproductive Care (minors only)

MINORS: A minor patient's signature is required in order to release the following information: (1) Conditions relating to the minor's reproductive care including, but not limited to contraception, Pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

Signature of Minor: ____________________________________

Date: ______________________________________
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