



*Women's Integrative Health*

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477 N. El Camino Real Suite C304

Encinitas, CA 92024

PH: (760) 635-3777

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**Authorization for release of medical information**

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Date: \_\_\_\_\_

Please **REQUEST** Medical Information from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I authorize release of a copy of my medical records to:**

**Women's Integrative Health**  
**477 N. El Camino Real, Suite C304**  
**Encinitas, CA 92024**  
**FAX: (760) 942-7163**

**Records to be released:** \_\_\_\_\_

**Duration:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date) or for one year from the date of signature if no date entered.

**Use of information:** The requestor may use the medical records and type of information authorized only for the following purposes:

Continuing Care    Second Opinion    Personal    Insurance Claim    Other: \_\_\_\_\_

**Re-disclosure:** I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

**Revocation:** this authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

**Name of Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**X** \_\_\_\_\_  
**Signature of Patient or Patient's Representative**

\_\_\_\_\_ **Indicate Relationship (if Signed by Other than Patient)**