



Women's Integrative Health

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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: _____

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

Please release a copy of my medical records to:

Name: _____

Address: _____

Phone: _____

Records to be released: _____ Results; or
_____ All History, including: _____ psychiatric information,
_____ sexually transmitted disease information (including HIV),
_____ substance abuse information and _____ physical or sexual abuse
information.

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 requester 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)