

**LAGUNA BEACH OBSTETRICS & GYNECOLOGY**

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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:**

**Medical information released to:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

FAX: \_\_\_\_\_

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: \_\_\_\_\_  
\_\_\_\_\_