

**Ventura County
Obstetric & Gynecologic
Medical Group, Inc.**

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Tax ID #953152550

Release of Medical Records

To: _____
Doctor of Facility Name

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I authorize and request release of my medical records to:

To: _____
Doctor of Facility Name

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Records Requesting:

- | | |
|---|---|
| <input type="checkbox"/> Complete Medical Records | <input type="checkbox"/> X-ray/Ultrasound Reports |
| <input type="checkbox"/> H&P / Operative Report | <input type="checkbox"/> Pathology/Pap Smears |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> ER Reports |
| <input type="checkbox"/> Other: (Specify) _____ | |

I am requesting records for the treatment period of: _____ to _____

Patient Name: _____
Last First MI

Other Name(s) Used: _____

DOB: _____ Patient Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Patient Signature: _____ Date: _____

Legal Representative, indicate name and relation: _____