



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Account Number _____

I, _____, give Temecula Valley OB/GYN Medical Associates permission to release **CONFIDENTIAL** and **PERSONAL MEDICAL INFORMATION, EXCLUDING HIV**, to the following person:

Name: _____

Address: _____

Phone: _____

 Patient Name (Please Print)

 Date of Birth

 Patient Signature

 Date

 Witness

 Date

"A Practice Specializing in Women's Health Care"

Timothy Elfelt, MD Joseph Glaser, MD Debra Lebo, DO Charles Yang, MD Tammy Hayton, MD
 Lorna Laney, RNP Nancy Ferrell, RNP Linda Leon, RNP