

Are you a new patient? Please fill out this release form and mail it to your previous doctor.

PERMISSION TO SEND MY MEDICAL RECORD TO DR. MENDELSSOHN

This authorization is for the use or disclosure of my health information and is required by state and federal law. I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment. Allow up to 30 days for processing.

I HEREBY AUTHORIZE:

Physician/Organization That Has My Medical Record _____

Telephone Number _____

Street Address _____

City, State, ZIP _____

TO DISCLOSE TO: Andrea Mendelsohn, MD, FACOG
3000 Colby Street, Suite 101
Berkeley, CA 94705
(510) 649-9200 / (510) 649-9222 fax

MEDICAL RECORDS AND INFORMATION PERTAINING TO:

My Name _____ My Birth Date _____

My Telephone Number _____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here:

REVOCACTION: This authorization is also subject to written revocation by me at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have already acted in reliance upon this authorization.

REDISCLASURE: I understand that the office of Dr. Mendelsohn may not lawfully further use or disclose the health information unless another authorization is obtained by me or unless such use or disclosure is specifically required or permitted by law. This protection does not extend to recipients outside the state of California.

PLEASE CHOOSE FROM THE FOLLOWING:

Release to Dr. Mendelsohn my COMPLETE and ENTIRE Medical Record, including Drug/Alcohol, HIV, Mental Health, & Genetic Records.

Release Other (please specify): _____

Signature _____ Date _____

If signed by other than patient, indicate relationship: _____

A copy of this authorization is as valid as the original. Patient has a right to a copy of this authorization.