THIS FORM IS OPTIONAL .... PLEASE FILL OUT THIS FORM IF YOU WOULD LIKE OUR OFFICE TO REQUEST RECORDS FROM YOUR PREVIOUS DOCTOR.

MEDICAL RECORDS RELEASE

All About Women Obstetrics and Gynecology
17183 Interstate 45 South, Suite 410
The Woodlands, TX 77385
281-602-7380
281-602-7386 (Fax)

Patient Name: ____

DOB: ______________________ SS# ______________________________

This is an authorization to release the information contained in my medical records

Medical records requested from:

Doctor Name: ____

Phone: ______________________ Fax: ______________________

Address: ____

Medical records sent to:

Doctor Name: ____

Phone: ______________________ Fax: ______________________

Address: ____

Reason you are transferring records ______________________________

Please check information desired to be transferred

____ Entire Record
____ Obstetrical Record
____ Lab Reports
____ Mammogram Reports

I understand that the information used or disclosed may be subject to disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations. I may revoke or withdraw the authorization by notifying All About Women Obstetrics and Gynecology in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition her treatment of me on whether or not I sign the authorization.

Patient Signature: ______________________________ Date: ______________

Signature of Parent/Guardian: ______________________ Date: ______________
(if Minor)

This release expires one year from date of signing