

PLEASE FILL OUT THIS FORM IF YOU WOULD LIKE OUR OFFICE TO HAVE RECORDS FROM PREVIOUS/PRESENT DOCTOR. THIS IS OPTIONAL. IF YOU HAVE MORE THAN 1 DOCTOR TO REQUEST RECORDS FROM PLEASE ASK FOR ANOTHER FORM.

Medical Records Release

Women Of the Woodlands
9200 Pinecroft Suite 400
The Woodlands Texas, 77380
(281)292-5774
(281)292-5780 fax#

Patient Name: _____

Birth Date: _____ SS# _____

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

Medical records requested from:

Doctor name _____

Phone # _____ Fax # _____

Address _____

Dates of service _____

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 _____

In addition, I authorize that this will include health information relating to (check if applicable)

- Genetic testing
- HIV/AIDS infection
- Drug/alcohol abuse

I understand that the information used or disclosed may be subject to re 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 Women of The Woodlands in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reverse, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Patient

Date:

Signature of Parent or Guardian (if minor)

Date:

Witness of Signature

Date:

This release expires in one year of signing.