



7777 Southwest Freeway, Suite 454, Houston, TX - 77074  
Tel: 281-953-1710, Fax: 281-953-1714

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, hereby authorize Women's OBGYN Care to request records on my behalf

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**To:**  
**Women's OBGYN Care**  
Dr. Jayshree Patel, MD FACOG  
7777 Southwest Freeway, Suite 454  
Houston, TX 77074

**From:**  
Office : \_\_\_\_\_  
Physician : \_\_\_\_\_  
Address : \_\_\_\_\_  
Phone : \_\_\_\_\_  
Fax : \_\_\_\_\_

**Specify requested dates of service:**  
From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_

**Purpose of Release:**

- Changing Physicians
- Specialist
- Personal
- Continuation of Care
- PCP

**Specific Records Requested:**

- Office Notes
- Laboratory Reports
- Other \_\_\_\_\_
- Radiology Reports
- Entire Medical Records
- Operative Reports
- Discharge Records

**I consent to the release of any information regarding HIV, AIDS, sexually transmitted infections, drug or alcohol use, psychiatric and mental health conditions.**  
**Initial** \_\_\_\_\_

I understand that this authorization will remain in effect unless revoked by me in writing. I hereby release the facility, its employees and officers, appointed representatives and attending physicians from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Name and Signature of Patient / Guardian

\_\_\_\_\_  
Relationship to Patient