Women's OBGYN care
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