NORTH TEXAS
OB-GYN ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

I hereby authorize: (Office in which records will be coming from)

Provider Name: _____

Address: _____

Phone: _____

Fax: _____

To furnish: (Check all that applies) ___ Complete Medical Records (Circle: DO/ DO NOT include HIV and Genetic Testing) ___Lab Reports (Circle: DO/ DO NOT include HIV and Genetic Testing) ___Pathology Reports ___Radiology ___ Office Notes ___ Operative Report: ___Other:_____

Reason for request: ____Medical Care ____ Location/Moved ____Personal ____Insurance ____Second Opinion ____ Other: _____

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Approximate dates seen: _____

Please send my medical records to: (Circle One)

Rudy Tovar, M.D. Thomas Fliedner, M.D. Alexandra Goldman, M.D. Ashley Sbanotto, M.D.

Diana Luts, M.D. Cheryl Smitherman, CNM Mary Jane Flanagan, RN, FNP-C

Signed: _____ Relationship to Patient: _____

Witness: _____

Dates records sent: _____ Dates records received: _____

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