NORTH TEXAS
OB-GYN ASSOCIATES

Authorization for Release of Medical Information

Date of Request: _____

I, _____ *hereby authorize:*

North Texas OB-GYN Associates
328 W. Main St.
Lewisville, TX 75057

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 ___Personal ____Insurance ____Second Opinion ___ Attorney/Legal ____ Other: _____

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Approximate dates seen: _____

******PLEASE ALLOW 3-5 BUSINESS DAYS FOR RECORDS TO BE PROCESSED******

Please send my medical records to:

Facility Name/Provider Name: _____

Address:_____

Phone: _____ Fax: _____

Patient Signature:_____

Witness: _____

*****Please note this form expires one year from the date of the request unless otherwise agreed upon*****

Please fax request to: 972-221-8246

Date records sent: _____ Initials of Authorized Personnel _____ Signature of Provider: _____