NORTH TEXAS
OB-GYN ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (COMING HERE)

Date of Request: _____

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

Facility/Provider Name: _____

Address: _____

Phone: _____

Fax: _____

Approximate Dates Seen: _____

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 Reports
___ Other: _____

Reason for request:

____ Medical Care ____ Location/Moved ____ Personal ____ Insurance
____ Second Opinion ____ Other: _____

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Last 4 SSN#: _____

Please send my medical records to: (Circle One)

North Texas OB-GYN Thomas Fliedner, M.D. Alexandra Goldman, M.D. Alejandra Perez-Moore, M.D.

Rudy Tovar, M.D. Diana Luts, M.D. Ashley Sbanotto, M.D. Cheryl Smitherman, CNM Heather Caudell, CNM

Note: Unless otherwise revoked, this Authorization will expire six months from the date above or the following designated event: _____. I understand that authorizing the disclosure of this health information is voluntary.

Signed: _____ Relationship to Patient: _____

Witness: _____

Date Records Received: _____

328 W. Main St. * Lewisville, TX 75057 * (972) 436-7557 * Fax (972) 221-8246
3424 Long Prairie Rd, Suite 200 * Flower Mound, TX 75028