NORTH TEXAS
OB-GYN ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (LEAVING HERE)

Date of Request: _____

I hereby authorize:

North Texas OB-GYN Associates
328 W. Main St, Lewisville TX, 75057
Phone: 972-436-7557 Fax: 972-221-8246

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: _____

Phone Number: _____ Last 4 SSN#: _____

Approximate dates seen: _____

Please send my medical records to:

Facility/Provider Name: _____

Address: _____

Phone: _____

Fax: _____

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. Please allow 3-5 business days for records to be processed.

Patient Signature: _____

Witness: _____

Date Records Sent: _____ Initials of Authorized Personnel: _____ Provider Signature: _____