



# Women's Health Alliance

*Total Care, Total Trust... For Life*

www.womenshealthalliance.com

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## *Authorization for Release of Medical Information*

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Last Four of SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Records From:

Dr.'s Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

I hereby authorize and request my medical records be released to Dr. \_\_\_\_\_

\_\_\_\_\_ All medical history, physical exams, laboratory test

\_\_\_\_\_ Only operative records for surgery on \_\_\_\_\_

\_\_\_\_\_ Only laboratory test and pap smears

\_\_\_\_\_ All prenatal records

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please mail or fax the records requested to (circle one):**

Dallas: 3600 Gaston Avenue, Suite 300 Dallas, Texas 75246 Fax: 214-824-0541

Mesquite: 1600 Republic Parkway, Suite 160 Mesquite, Texas 75150 Fax: 972-613-8779