# Women's Health Medical Group, PA

## Consent for Release of Medical Records

I authorize the release of the following information from the records of

Patient _____

DOB_____ SS# _____

_____ Last 2 years of Medical Records

_____ Records of Treatment from _____ to _____

_____ Complete Medical Record excluding _____

_____ Complete Medical Record

| Please obtain records from: | Please release records to: |
|---|---|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Phone #: _____ | Phone #: _____ |
| Fax#: _____ | Fax #: _____ |

Reason for request:

_____ Consult with other physician** _____ Transfer to another physician**

_____ Billing _____ Insurance

_____ Personal use (Fee _____)

** will release directly to physician without fee

I understand that these records are confidential and cannot be disclosed without written authorization, except otherwise as provided by law. May consent may be revoked at anytime. This authorization shall expire ninety days from the date of my signature. The ability or inability to condition treatment, payment, enrollment or eligibility for benefits is prohibited. I understand that the potential for information that was disclosed may be subject to re-disclosure by the recipient and no longer be protected by this Policy.

Women's Health Medical Group, PA, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signature of Patient or Legal Guardian Date

6100 Harris Parkway, Ste. 140, Fort Worth, TX 76132 817-346-5336 817-263-3758 Fax