Susan Sugerman, MD, MPH
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17300 Preston Road, Suite 160, Dallas, TX 75252
Phone: 972-733-6565 **Fax: 972-733-6564**

CONSENT TO OBTAIN AND/OR RELEASE MEDICAL RECORDS

Patient Name: ____ Date of Birth: _____/_____/_____

Please release my medical records and allow communication between
Girls to Women Health & Wellness and the following providers:

Name: ____ **Phone:** ____________________________

Address: ____ **Fax:** ____________________________

- ☐ MEDICAL Records including Medical Summary, Immunization/Growth Charts, Lab/Radiology Reports
- ☐ Psychiatric/Psychological Records
- ☐ Communication between providers as needed including medical and psychological record information
- ☐ Other (please specify): ____

Name: ____ **Phone:** ____________________________

Address: ____ **Fax:** ____________________________

- ☐ MEDICAL Records including Medical Summary, Immunization/Growth Charts, Lab/Radiology Reports
- ☐ Psychiatric/Psychological Records
- ☐ Communication between providers as needed including medical and psychological record information
- ☐ Other (please specify): ____

Name: ____ **Phone:** ____________________________

Address: ____ **Fax:** ____________________________

- ☐ MEDICAL Records including Medical Summary, Immunization/Growth Charts, Lab/Radiology Reports
- ☐ Psychiatric/Psychological Records
- ☐ Communication between providers as needed including medical and psychological record information
- ☐ Other (please specify): ____

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation will be effective upon receipt by Girls to Women Health and Wellness, PA. I have read and understand the terms of this Authorization, and hereby knowingly and voluntarily authorize Girls to Women Health and Wellness, PA to use or disclose my health information in the manner described above. This authorization expires upon my written request.

______________________________	X______________________________	_____/_____/______
Patient Name (print)	Patient Signature (adult patients only)	Date
______________________________	X______________________________	_____/_____/______
Parent/Guardian (print) (if patient is a minor)	Parent/Guardian Signature (if patient is a minor)	Date

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