



CONSENT TO OBTAIN AND/OR RELEASE MEDICAL RECORDS

Patient Last Name, First Name, (Nickname, if applies), Date of Birth, Address, City and State, Zip, Home Phone, Patient Cell

The purpose of this disclosure is: ___ at my request ___ for continuing health care ___ other:

PLEASE RELEASE MY MEDICAL RECORDS FROM [] TO []:

Name, Address, City, State, Zip, Phone, Fax

- RECORDS TO INCLUDE THE FOLLOWING: [] All MEDICAL Records, [] Immunization Records, [] Growth Charts, [] Lab Reports, [] Radiology Reports, [] Communication between providers as needed including medical and psychological record information, [] Records dated ___ to ___, [] Medical Summary (if applicable), [] Consult Notes, [] Psychological Records, [] Other (please specify):

PLEASE RELEASE MY MEDICAL RECORDS FROM [] TO []:

Girls to Women Health & Wellness, 17300 Preston Road, Suite 160, Dallas, TX 75252 Ph: 972-733-6565 F: 972-733-6564

- RECORDS TO INCLUDE THE FOLLOWING: [] All MEDICAL Records, [] Immunization Records, [] Growth Charts, [] Lab Reports, [] Radiology Reports, [] Communication between providers as needed including medical and psychological record information, [] Records dated ___ to ___, [] Medical Summary (if applicable), [] Consult Notes, [] Psychological Records, [] 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.

Patient Name (print), Patient Signature (adult patients only), Date, Parent/Guardian (print) (if patient is a minor), Parent/Guardian Signature (if patient is a minor), Date