Texas Premier Ob/Gyn Center

MEDICAL RECORD RELEASE FORM

Please complete this form and mail or fax to the physician. hospital, or organization from which you are requesting records. This information will then be forwarded directly to our office, Thank you.

I hereby authorize:

Address--- _

City, State, Zip _ ______________________ _____

Telephones __ __________________ Fax# ___ _

to release the following information from the health records) of

Patient Name

Address_ _

Date of Birth ________________ . _______Social Security # _______________________ _

Covering the period of treatment:

From

To -___ _ _ . _ . _ _

This information is to be released to:

Texas Premier Obgyn Center
5934 W Parker Road, Suite 500
Plano Texas 75093
Phone 972-473-0973
Fax 972-473-0473

Date

Patient Signature

Witness Signature