

Contemporary Women's Care
4323 N. Josey Lane, Suite 306
Carrollton, TX 75010
Phone: 972-939-7011 Fax: 972-939-2951

Medical Record Release

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

I hereby request and consent to the release of my medical records (check one below):

REQUEST my medical records FROM the following:

RELEASE my medical records TO the following:

Doctor/Hospital: _____

Address _____

City/State/Zip: _____

Phone Number: _____ Fax Number: _____

Reason for release of records: _____

CHECK ALL that apply to this record release request:

ALL medical records

Lab and Diagnostic Studies only (or specific date range stated below)

GYN records only Obstetrical Record only

Do NOT release these records (list): _____

OTHER _____

I understand that all information I consent to be obtained/released will be protected as required under the HIPAA Privacy Regulations. I understand that I may withdraw this consent at any time by written request. I understand there is a fee for copying/releasing medical records, \$25 for up to 60 pages and \$40 for records exceeding 60 pages. Records released to another physician will not incur a charge. I further understand my records will not be released until paid for. I have been informed that medical records are not faxed and are mailed, unless there is an urgent need for a diagnostic test result.

Signature: _____ Date: _____