Contemporary Women's Care
6020 W Parker, Suite 330
Plano, TX 75093
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/Sate/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:_____________________