

Women's Health Care Center of Houston

OBSTETRICS • GYNECOLOGY • INFERTILITY

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PATIENTS: Please fill in the doctor's name on the first line, and the dates of the records that you want them to send to Women's Health Care Center of Houston. If you want all your records sent to us, simply write the word "ALL" on the date area. Send completed form to your previous doctor's office. **Form must be SIGNED, dated and witnessed to be valid.**

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION TO WOMEN'S HEALTH CARE CENTER OF HOUSTON

I hereby authorize Dr. _____ at address _____
Physician or Facility Name

_____, _____, _____ Phone No.: _____ Fax: _____
City State Zip Code

to furnish a copy of my Medical record to Women's Health Care Center of Houston for the period dated:

From _____ Through _____
Month, Day, Year Month, Day, Year

Mail, Fax, or email records to:

WOMEN'S HEALTH CARE CENTER OF HOUSTON
929 Gessner Rd., Suite 2225
Houston, Texas 77024

Medical Records: 713-365-2934 FAX 713-461-8133 e-mail: fnash@whcch.com

This authorization is valid for 90 days from the date of signature by the patient or guardian. Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains. This authorization releases you, your physicians and employees from liability for following this authorization request.

Signature of Patient: _____ Date: _____

Patient's Printed Name: _____ Date of Birth: _____

Patient's Address: _____, City: _____

State: _____ Zip Code: _____ Phone Number: _____

Witness' Signature: _____ Date: _____

Witness' Printed Name: _____

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