



REQUEST FOR INFORMATION

ON THIS DATE _____ I HERBY AUTHORIZE:

NAME (YOUR PREVIOUS DOCTOR OR FACILITY; COMPLETE IN FULL) PHONE NUMBER
STREET ADDRESS CITY STATE ZIP

TO FURNISH A COPY OF MEDICAL RECORDS, THIS MAY INCLUDE INFORMATION CONCERNING THE RESULTS AND/OR TREATMENT OF HIV, AIDS, MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE, OF THE PATIENT LISTED BELOW UPON MAKING REQUEST. I HEREBY RELEASE YOU, YOUR PHYSICIANS AND EMPLOYEES FROM LIABILITY FOR FOLLOWING THIS AUTHORIZED RELEASE FORM.

TO: MEDICAL RECORDS
GREATCARE OBGYN, PLLC.
18400 KATY FREEWAY, STE. 260
HOUSTON, TEXAS 77094 PHONE 832-230-2900
FAX NO. 281-579-1146

PLEASE COMPLETE ALL INFORMATION, INCOMPLETE OR ALTERED FORMS WILL NOT BE PROCESSED

SPECIAL INFORMATION REQUESTED: PLEASE SPECIFY TIME PERIOD REQUESTED, PLEASE DO NOT SELECT ALL.

DATE OF SERVICE: FROM _____ TO _____ (PLEASE CHECK ONE)

- PAP SMEAR
OFFICE NOTES
LABS
MAMMOGRAPHY
OPERATIVE REPORTS
PRENATAL RECORDS
ALL RECORDS

THIS AUTHORIZATION IS VALID FOR 120 DAYS FROM THE DATE OF SIGNATURE. ANY CHANGE IN AUTHORIZATION MUST BE IN WRITING.

REGARDING (PATIENT NAME)
SS NO. DATE OF BIRTH
ADDRESS
CITY, STATE & ZIP PHONE
PATIENT SIGNATURE DATE

FOR OFFICE USE ONLY

DATE REQUESTED _____ REQUESTED BY DR. _____

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