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.
18300 KATY FREEWAY, STE. 485
HOUSTON, TEXAS 77094 PHONE 832-230-2900
FAX NO. 281-579-1146

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****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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