



Healthcare for Women by Women

Sign Off: _____
Date Faxed: _____
Date Mailed: _____
Processed by: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Jane C. Reed, M.D., F.A.C.O.G. Tracy Turner, M.D., F.A.C.O.G. Shelby Hampton, M.D.
Mary Prentice, M.D., F.A.C.O.G. Joan Stokes, R.N., W.H.N.P. Karen Brock, R.N.C., N.P., C.N.M.

I hereby authorize the release of information from the medical records of:

Patient Name _____ DOB _____

Social Security # _____ Daytime Phone # _____

Information Release To:

Name _____
Address _____
Phone _____

From:

SPECIALISTS FOR WOMEN
9200 Pinecroft Drive #350
The Woodlands, TX 77380
OFC) 281-363-2426 FAX) 281-362-1263

ALL INFORMATION IS REQUIRED TO PROCESS

Please release the following:

- Problem List X-Ray Reports
Progress Notes EKG Reports
History/Physical Exam Other Diagnostic Report Specify
Lab Reports Other (Specify)

Purpose or need for disclosure:

- Continued Care Personal Use Other
Attorney/Legal Insurance Claim/Application
Disability Determination Insurance Change

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at anytime except to the extent that action has been taken. This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature of Patient or Legal Guardian

Date

Relationship to Patient

Witness