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|---------------------|
| Date Faxed: _____   |
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**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 L. 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:  
 SPECIALISTS FOR WOMEN  
 9200 Pincroft Drive #350  
 The Woodlands, TX 77380  
 OFC) 281-363-2426 FAX) 281-362-1263

From:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PHONE AND/OR FAX #'S ARE REQUIRED

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