

Date Received by Care For Women _____
Employee's Initials: _____

Office Telephone (281) 359-7000 ext 149
Office Fax (281) 359-5833

**PLEASE ALLOW 10 TO
14 BUSINESS DAYS FOR
RECORDS TO BE
PROCESSED/COPIED**

Phone: 281-359-7000
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Obstetrics & Gynecology

Medical Records Request/Release

First Name of Patient _____
Social Security # _____ - _____ - _____ Date of Birth ____/____/____
Address _____ City _____ State _____
Zip code _____ Phone Number (____) _____ - _____ Cell Number (____) _____ - _____

Please Check ONE of the following options:

- I wish to request my medical records from the doctor(s) listed below to be sent to Care For Women.
- I wish to request my medical records to be sent from Care For Women to the doctor(s) listed below.

Physician(s) you would like Care For Women to send records to, or request from: <u>PLEASE COMPLETE IN FULL OR RECORDS MAY NOT BE ABLE TO BE SENT OR RECEIVED</u>	
Dr. _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____ Authorization covers care given during the following dates: From: _____ To: _____	Dr. _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____ Authorization covers care given during the following dates: From: _____ To: _____
Dr. _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____ Authorization covers care given during the following dates: From: _____ To: _____	Dr. _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____ Authorization covers care given during the following dates: From: _____ To: _____

The records or information I wish to be sent or received are: (check all that apply)

- History Physical Progress Notes Lab Reports X-Ray/Mammo EKG Reports
- Operative Reports Care Plan Therapy Reports Psychological Reports
- Other (please specify): _____

The reason I want these records or information transferred is:

- For Medical Care To go to an attorney To go to my insurance company Other (please specify): _____
 - This authorization is valid for a period of 120 days from the date of the signature below, and can be revoked/cancelled in writing at any time prior to the expiration date.
 - The patient agrees that a copy of this authorization may be considered valid : yes _____ no _____
 - Are you pregnant at this time? Yes _____ No _____
 - Are you transferring care to another physician? Yes _____ No _____
 - If so, please explain why: _____

Patients Signature Authoring Request/Release:

Signature: _____ Date: _____

Physician's Signature Authorizing Request/Release:

Signature: _____ Date: _____