Phone: 281-359-7000
350 Kingwood Medical Drive, Suite 300
Kingwood, TX 77339
www.CareForWomenOnline.com

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

Office Telephone (281) 359-7000 x 149
Office Fax (281) 359 – 5833

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

Medical Records Request/Release

Full Name of Patient_____ Date of Birth____/____/_____
Social Security #_____ Home Telephone (_____) _____ Cell (____)_____
Address_____ City_____ State_____
Zip code_____

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

Physician(s) you would like Care for Women to send records to, or request from:
PLEASE COMPLETE ALL HIGHLIGHTED FIELDS

Dr. _____
Address: _____
City/State/Zip: _____
Telephone: (_____)_____
Fax: (_____)_____
Authorization covers care given during the following dates:
From:_____ To:_____

Dr. _____
Address: _____
City/State/Zip: _____
Telephone: (_____)_____
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 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 your care to another physician? _____yes _____no
  - If so, please explain why: _____

Patient's Signature Authorizing Request/Release:
Signature: _____ **Date**: _____

Physician's Signature Authorizing Release/Request of Records:
Signature: _____ Date: _____

If records are being requested by the patient or being sent to any other facility other than a healthcare provider, there is a $25 dollar charge for the 1st 20 pages of medical records and .15 cents for any page thereafter. There is no charge for records being sent to another healthcare provider.