350 Kingwood Medical Drive, Suite 350
Kingwood, TX 77339
P: (281)359-7000 x149
F: (281)359-5833
www.careforwomenonline.com
E-Mail to: careforwomen@earthlink.net

PLEASE ALLOW 10-14 BUSINESS DAYS FOR PROCESSING

Medical Record Release/Request Form

CARE FOR WOMEN
Angela Adomako, M.D.
Jennifer Browning, M.D.
Stephanie Champion, M.D.
Karen McNeal, MSN, APRN, CNM
Kavita Mahajan-Merriit, D.O.
Sujatha Mohan, M.D.
Lyndsay Rodriguez, M.D.
Brenda Uribe-Torres, M.D.
Rachel Towns, M.D.
Cindy Turco, M.D.
Sharon Zavala, M.D.

Full Name: _____ Date of Birth: __/___/_____
Last 4 digits of SS#_____ Cell #:_____Home #:_____
Address: _____ City: _____
State: _____ Zip Code: _____

Please check which option you would like to have done:

- ☐ I would like to request my records to be sent **TO** Care for Women from (fill in box below.)
- ☐ I would like my records to be released **FROM** Care for Women and sent to (fill in box below.).
- ☐ I would like a copy of my medical records for myself and understand that there may be a fee for processing. (Please write SELF on Name of Dr. or Facility line in box below.)

YOU **MUST** COMPLETE **ALL** FIELDS IN ORDER TO ENSURE PROCESSING!
Name of Dr. or Facility: _____
Address:_____
City/State/Zip Code:_____
Phone #:_____
Fax #:_____
This authorization covers care given during the following dates
From:_____ To:_____
Please flip over for more boxes

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

- ☐ History & Physical/ Care Plan
- ☐ Office Notes
- ☐ Lab Results
- ☐ Mammograms, Bone Density, Ultrasounds
- ☐ Pathology/Operative Reports
- ☐ Mental Health Records (Excluding psychotherapy notes)
- ☐ Billing Records
- ☐ Other:_____

Records are needed for: (check all that apply):

- ☐ Medical Care
- ☐ For an attorney
- ☐ For an insurance company
- ☐ Other:_____

- This authorization is valid for 120 days from the date of 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 & HIPPA compliant. _____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
Signature: _____Date: _____

Physician
Signature: _____Date: _____

Please Note: If records are being requested by the patient or being sent to any other facility other than a healthcare provider, there is a $25 charge for the first 20 pages of records and .15cents for any page thereafter. There is no charge for records being sent to another healthcare provider. By signing above, you agree to these terms.

YOU **MUST** COMPLETE **ALL** FIELDS IN ORDER TO ENSURE PROCESSING!

Name of Dr. or Facility: _____

Address: _____

City/State/Zip Code: _____

Phone #: _____

Fax #: _____

This authorization covers care given during the following dates

From: _____ To: _____

YOU **MUST** COMPLETE **ALL** FIELDS IN ORDER TO ENSURE PROCESSING!

Name of Dr. or Facility: _____

Address: _____

City/State/Zip Code: _____

Phone #: _____

Fax #: _____

This authorization covers care given during the following dates

From: _____ To: _____

YOU **MUST** COMPLETE **ALL** FIELDS IN ORDER TO ENSURE PROCESSING!

Name of Dr. or Facility: _____

Address: _____

City/State/Zip Code: _____

Phone #: _____

Fax #: _____

This authorization covers care given during the following dates

From: _____ To: _____

Additional Information regarding request/release of records:

- Forms may be submitted via email to careforwomen@earthlink.net Attn: Medical Records in the subject line, by fax or by mail.
- Same day requests are not permitted.
- Records cannot be released via email, but may be made available on the patient portal on careforwomenonline.com, or, if under 20 pages via fax or by mail.
- Make sure to fill out form in its entirety to ensure proper processing times.
- For further assistance please leave a voicemail for the medical records department at (281)359-7000 x149.

THANK YOU!