



MEDICAL RECORDS RELEASE

Fax to 281-392-7911

There is a \$25 charge for the first 20 pages or less, and 15¢ for each additional page after 20. This fee must be paid BEFORE documents are produced.

Please fill in all blanks: incomplete or altered forms will be returned by mail for completion before processing.

Allow 2 weeks to process completed requests.

I HEREBY AUTHORIZE:

Premier OB/GYN of West Houston, L.L.P.
18300 Katy Freeway, Suite 315
Houston, TX 77094

To furnish a copy of medical records, which may include information concerning the results and/or treatment of HIV, AIDS, Mental Health, Alcohol and/or Drug Abuse, of the patient listed below. Upon making this request, I hereby release you, your physicians and employees from liability for following this authorization request.

To: Name Phone

Mailing Address City St Zip Code

For the purpose of:

- Insurance Claim Pending
Second Opinion
Application for Life/Health Insurance
Legal Representation
Primary Care Physician
Due to Insurance Coverage (Insurance Co)
Moving out of Town
Changing Physicians

INFORMATION TO BE RELEASED: Please specify which time period is requested.

Date of Service: From to

- Pap Smear Office Notes Labs Mammography Operative Report Prenatal Record
All Records Other

This authorization is valid for 120 days from the date of signature. Any change in authorization must be in writing.

Regarding (Patient Name)

SS # Date of Birth

Address

City, State, Zip Code

Home Phone Work Phone

Patient Signature Date
Guardian, if minor

This document or documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of the information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after stated need has been fulfilled.

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