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214-377-7252 (P)  
1-888-761-4153 (F)

## MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize **Maternal Fetal Medicine Consultants of Dallas**, as listed below, to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information:

**Maternal Fetal Medicine Consultants of Dallas**  
**8160 Walnut Hill Lane Suite 324**  
**Dallas, Texas 75231**  
**Phone: 214-377-7252**  
**Fax: 1-888-761-4153**

For treatment for the period:

From \_\_\_\_\_ (date) To \_\_\_\_\_ (date)

The information I request to be released is as follows:

<input type="checkbox"/> Complete records	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Care plan	<input type="checkbox"/> Lab reports	<input type="checkbox"/> Radiology reports
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Treatment Record	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Hospital Reports	<input type="checkbox"/> Medication record	<input type="checkbox"/> Other (please specify)

The purpose/reason for this release of information is as follows:

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Release my protected health information to the following the physician/person/facility/entity listed below:

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Facility requesting records/Facility to send records to

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Date