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8160 Walnut Hill Lane Ste 324
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214-377-7252 (P)
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MEDICAL RECORDS REQUEST FORM

By signing this form, I authorize physician/person/facility/entity 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, to the physician/person/facility/entity listed below:

Physician/Facility Name:

Address:	City:	State:	Zip:
Phone:	Fax:		

From _____(date) To_____(date)

The information that you may release subject to this signed release for is as follows:

____Complete records	____History and Physical	____Progress Notes
____Care plan	____Lab reports	____Radiology reports
____Pathology Reports	____Treatment Record	____Operative Reports
____Hospital Reports	____Medication record	____Other (please specify)

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

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

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

_____ _____
Patient Name Signature of Patient or Authorized Representative

_____ _____
Patient Date of Birth Date