Gynecological & Obstetrical Associates

8160 Walnut Hill Lane, Suite 100, Dallas, Texas 75231 Phone: 214-369-1203 Fax: 214-369-0586
Please SIGN the form to validate release of records and return via fax/email: frontdesk@gynob.net

Rebecca Weprin, MD David Lombardi, MD Sheila Chhutani, MD
Laura Rosenfield, MD Clara Telford, MD

PATIENT Name: _____ Date of Birth: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby grant permission for release of medical information relating to my care from the following parties:

Previous/Current Doctor_____

Phone:_____Address:_____

FAX:_____

REQUESTING MEDICAL RECORDS BE SENT TO THE FOLLOWING:

I hereby grant permission to the following party to receive/evaluate medical information relating to my care:

Physician Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

PLEASE SEND THE FOLLOWING RECORDS:

1. Entire Chart - This information might include: HIV Testing and/or AIDS Treatment, Substance Abuse Treatment and/or Rehabilitation and Psychiatric Testing and/or Treatment.

OR

2. Specific Information to be released: Please specify exactly what you would like submitted (i.e., labs, mammogram results, pathology reports)

_____
_____
_____

I understand that this authorization may be withdrawn at any time in writing. This authorization will remain in effect for 90 days after I sign and date the form. Recipients of my information are forbidden from re-disclosure without my specific authorization. A facsimile may be utilized with the same effectiveness as the original.

Signature: _____ Date: _____

092023