REQUEST FOR
RELEASE OF MEDICAL RECORDS

TO: _____

_____

Phone: _____ **Fax:** _____

This authorizes you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information.

- ☐ Complete Record
- ☐ Records of care from the following dates: _____ to _____
- ☐ Records concerning the following conditions: _____
- ☐ Other, please specify: _____
- ☐ Confer with the person(s) listed below orally about my medical information:

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial**: _____ **Date**: _____

Release to the following person(s):

Center for Women's Health

C. Funsho Fagbohun, MD, PhD, FACOG, FACS
Kesha S. Robertson, MD, FACOG
Cynthia I. Rios, MD, FACOG
Sarah D. Nelson, MD
Sabina K. Cherian, MD

Fort Bend Doctors' Pavilion
1601 Liberty Street, Suite A
Richmond, TX 77469

Phone: 281-342-MYOB (6962)
Fax: 281-342-6963
email: info@mywomensdoc.com

The reasons or purposes for this release of information are as follows:

_____

_____

Patient's Name: _____ **Date**: _____

Date of birth: _____ **Social Security Number**: _____-_____-_____

Patient's Signature: _____ **Witness**: _____