Contemporary Women's Care
6020 W Parker, Suite 330
Plano, TX 75093
Phone: 469-367-0225 Fax: 469-367-0430

Medical Record Release

Patient Name:_____ Date of Birth: _____

Social Security Number:_____ Phone: _____

I **hereby request and consent to the release of my medical records (check one below):**

- ☐ REQUEST my medical records FROM the following:
- ☐ RELEASE my medical records TO the following:

Doctor/Hospital:_____

Address_____

City/Sate/Zip:_____

Phone Number: _____ Fax Number:_____

Reason for release of records:_____

CHECK ALL that apply to this record release request:

- ☐ ALL medical records
- ☐ Lab and Diagnostic Studies only (or specific date range stated below)
- ☐ GYN records only ☐ Obstetrical Record only
- ☐ Do NOT release these records (list): _____
- ☐ OTHER _____

I understand that all information I consent to be obtained/released will be protected as required under the HIPAA Privacy Regulations. I understand that I may withdraw this consent at any time by written request. I understand there is a fee for copying/releasing medical records, $25 for up to 60 pages and $40 for records exceeding 60 pages. Records released to another physician will not incur a charge. I further understand my records will not be released until paid for. I have been informed that medical records are not faxed and are mailed, unless there is an urgent need for a diagnostic test result.

Signature:_____ Date:_____