Women's Health Care Center of Houston

OBSTETRICS • GYNECOLOGY • INFERTILITY

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PATIENTS: Please fill in the doctor's name on the first line, and the dates of the records that you want them to send to Women's Health Care Center of Houston. If you want all your records sent to us, simply write the word "All" on the date area. Send completed form to your previous doctor's office.
Form must be SIGNED, dated, and witnessed to be valid.

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION TO WOMEN'S HEALTH CARE CENTER OF HOUSTON

I hereby authorize Dr. _____
(Physician or Facility Name)

At address: _____
(Street) (City) (State) (Zip)

Phone Number: _____ Fax: _____

To furnish a copy of my Medical record to Women's Health Care Center of Houston for the period dated:

From: _____ Through: _____
MONTH, DAY, YEAR MONTH, DAY, YEAR

Mail, Fax, or email records to:

WOMEN'S HEALTH CARE CENTER OF HOUSTON
929 Gessner Rd., Suite 2225
Houston, TX 77024
Medical Records: 713-365-2934 **Fax**: 713-461-8133 **email:** admin@whcch.com

Signature of Patient: _____ **Date:** _____

Patient's Printed Name: _____ DOB: _____

Patient's Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Witness' Signature: _____ Date: _____

Witness' Printed Name: _____