



Theresa M. Conyac, MD
6705 Heritage Pkwy Ste 102 Rockwall, TX 75087
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Release for Medical Records

Dear : **GLOW** Theresa M.Conyac, MD 6705 Heritage Pkwy Ste 102 Rockwall, TX 75087
Phone: 972.722.2526 Fax: 972.722.2528

In Reference to Patient:

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security: _____

Address: _____

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

- _____ Complete record
- _____ Records of care from _____ to _____ only
- _____ Records of care concerning the following: _____

to the following person(s):

Doctor: _____

Address: _____

Phone: _____

Fax: _____

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 _____

The reasons or purposes for this release of information are for CONTINUING / TRANSFER of care.

Patient Signature: _____

Date: _____

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