6705 Heritage Pkwy Ste 102 Rockwall, TX 75087 Phone: 972.722.2526 Fax: 972.722.2528

Request for Medical Records

Dear Dr. ___________________________________,

Address: ____

Phone Number: ________________________ Fax Number: ___________________

In Reference to Patient:

Last Name: _________________________ First Name: ____________________ MI: __

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): **GLOW**

Theresa M.Conyac, MD

6705 Heritage Parkway Suite 102 Rockwall, Texas 75087

Phone: 972.722.2526 Fax: 972.722.2528

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:_________________________