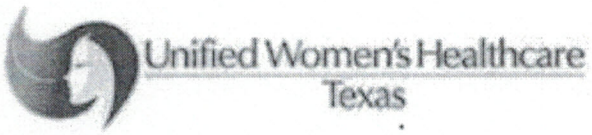

OBSTETRICS AND GYNECOLOGY ASSOCIATES OF DALLAS
3801 Gaston Avenue, Suite 200 Dallas, TX 75246
214.823.9630 214.821.3556 (fax)
www.obgadallas.com

MEDICAL RECORDS RELEASE FORM

TO: _____

_____

_____

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

_____ Complete record

_____ Records of care for the dates: _____ to _____

_____ Records concerning the following conditions: _____

_____ Other, please specify: _____

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

Initials: _____ **Date:** _____

RELEASE AND MAIL TO:
OBSTETRICS AND GYNECOLOGY ASSOCIATES OF DALLAS
3801 GASTON AVENUE, SUITE 200 DALLAS, TX 75246
214.823.9630 214.821.3556(fax)

The reasons or purpose for this release of information: _____

_____

Patient Name: _____ Date of Birth: _____

Address: _____

Patient Signature: _____ Date: _____