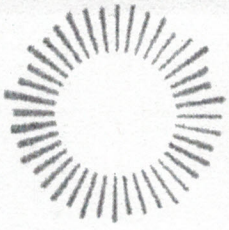

UWH OF TEXAS

OBSTETRICS AND GYNECOLOGY ASSOCIATES OF DALLAS
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214.823.9630 214.821.3556 (fax)
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MEDICAL RECORDS RELEASE FORM

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

_____ Complete record

_____ Records of care from the following 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 to the following person(s):

Name: _____

Address: _____

City/State/Zip: _____

Telephone number: _____ Fax number: _____

REASON FOR THE RELEASE: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip:

_____

Patient Signature: _____ Date: _____