



**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: _____