OBSTETRICS AND GYNECOLOGY ASSOCIATES OF DALLAS

OBSTETRICS, INFERTILITY AND GYNECOLOGY

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Dallas, TX 75246

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Frisco, TX 75034

214.823.9630 214.821.3556 (fax)

www.obgadallas.com

MEDICAL RECORDS RELEASE FORM

TO: ____

____

____

This authorizes you to provide a copy, summary, or narrrative 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: _______________

Glen W. Heckman, MD * Steven A. Harris, MD * Dale R. Ehmer, MD
Ashwin G. Gaitonde, MD * Linden R. Collins, MD