Jennifer C. Brooks, M.D., F. A. C. O. G.

Gynecology

1001 12th Avenue, Suite 150 Fort Worth, Texas 76104

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Dear Dr. ____:

This letter will authorize you to provide a copy, summary, or narrative of my medical records *(as indicated by the check mark below)*

____ Complete record

____ Records of care from _______________ to ______________ only ________

Records of care concerning the following condition(s):

____

____

____

Name_____________________________ DOB _____-_____-_______SS# _____-_____-______

Address____

City ____________________________ State ____________________ Zip Code _______________

The reason or purposes of this release of information are as follows:

____

Signature of patient or person legally authorized to consent on the patient's behalf:

Name: ____ Date: __________________________

I hereby authorize the release of my medical records to the following:

JENNIFER C BROOKS, M.D., F. A. C. O. G.
1001 12th AVENUE, STE. 150
FORT WORTH, TX. 76104

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