Dallas Women's Healthcare Specialists

AUTHORIZATION FOR RELEASE OF INFORMATION

Date_____

This is to certify that I, _____, grant permission to _____ to

___ release the information noted below from my medical records to:

- ___ medical provider_____
- ___ parents/guardian
- ___ myself
- ___ other _____

Recipient: Name_____

Address _____

_____

Information to be released:

- ___ All medical records to include all chart entries, diagnoses, test results, and reports.
- ___ All medical records except:

  _____
- ___ All records related to visits on the following dates:

  _____
- ___ All records related to the following dagnosis/symptoms:

  _____
- ___ Itemized bill* (includes diagnosis and itemized costs for service) for the following dates:_____
- ___ Progress notes and diagnoses only*
- ___ Test results only*
- ___ Consultant reports only*
- ___ Diagnosis only*

* Specify the dates, notes, results, reports, and/or diagnoses to be released.

Signed: _____

Witness: _____

Office Use Only:

Information released:_____

Date:_____

Released to:_____

By:_____