Women's Health Care Center of Houston

OBSTETRICS • GYNECOLOGY • INFERTILITY

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PATIENTS: Please fill in the doctor's name and complete address, phone number, fax number, and indicate dates or specific part of the records that you want Women's Health Care Center of Houston to release. You may mail this to us, fax to 713-461-8133, or email it to admin@whcch.com
Form must be SIGNED, dated, and witnessed to be valid.

AUTHORIZATION FOR WOMEN'S HEALTH CARE CENTER OF HOUSTON TO RELEASE HEALTH CARE INFORMATION TO ANOTHER FACILITY/DOCTOR

I hereby authorize WOMEN'S HEALTH CARE CENTER OF HOUSTON, 929 Gessner Rd., Suite 2225, Houston, Texas 77024 to release my medical records as listed below to:

Name of Doctor or Facility: ______________________________

Address to send records: ______________________________

City: ____________________, **State:** ________________, **Zip Code:** ____________

Phone Number: ____________________ **FAX:** ______________________________

Medical Records: All ______ **Specific report:** ______________________________ **OR**

All records dated from: ____________________ **through** ____________________
Month Day Year **Month Day Year**

This authorization is valid for 90 days from the date of signature by the patient or guardian. Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains. This authorization releases our physicians and employees from liability for following this Release of Information/Medical Records request.

Signature of Patient: ______________________________ **Date signed:** ______________

Patient's Printed Name: ______________________________ Date of Birth: ______________

Patient's Address: ______________________________, City ____________________
State: ____________ Zip Code: ______________ Phone Number ____________________

Witness' Signature: ______________________________ **Date signed:** ______________
Witness' Printed Name: ______________________________