

Women's Health Care Center of Houston
OBSTETRICS • GYNECOLOGY • INFERTILITY

Todd M. Holt, MD, FACOG
M. Elizabeth Hienaman, MD, FACOG
Michael D. Hold, MD, FACOG
Monique V. McKnight, MD, FACOG
Thao P. Vu, MD
Bimal R. Patel, D.O.

Mary Helen Tolentino, APRN, WHNP-BC
Joni Pheigaru, APRN, MSN, PNNP
Patricia A. Bruha, APRN, BSN, WHNP-BC
Ruth Preece, APRN, MSN, WHNP-BC
Lisa Elliott, APRN, MSN, WHNP-BC
Regina Ney, APRN, MSN, WHNP-BC
Marlene Cornelius, APRN, MSN, FNP-C

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: _____

Memorial City Office • Memorial Hermann Tower • 929 Gessner Road, Suite 2225 • Houston, Texas 77024-2584
Methodist West Houston Bldg. 1 • 18400 Katy Freeway, Suite 390 • Houston, Texas 77094-1287
Cy-Fair Office • 13114 FM 1960 West, Suite 105 • Houston, Texas 77065-5590
Tel: 713-365-2900 • Fax: 713-984-6525 • www.whcch.com