Women's Health Care Center of Houston

OBSTETRICS • GYNECOLOGY • INFERTILITY

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PATIENTS: Please fill in the doctor's name on the first line, and the dates of the records that you want them to send to Women's Health Care Center of Houston. If you want all your records sent to us, simply write the word "ALL" on the date area. Send completed form to your previous doctor's office. Form must be **SIGNED**, dated and witnessed to be valid.

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION TO WOMEN'S HEALTH CARE CENTER OF HOUSTON

I hereby authorize Dr. _____ at address _____
Physician or Facility Name

_____, _____ _____ Phone No: _____
City State Zip Code

Fax:_____

To furnish a copy of my Medical record to Women's Health Care Center of Houston for the period dated:

From_____ Through_____
Month, Day, Year Month, Day, Year

Mail, Fax, or email records to:
WOMEN'S HEALTH CARE CENTER OF HOUSTON
929 Gessner Rd., Suite 2225
Houston, Texas 77024
Medical Records: 713-365-2934 Fax: 713-461-8133 e-mail: admin@whcch.com

Signature of Patient:_____ Date: _____
Patient's Printed Name:_____ Date of Birth:_____
Patient's Address: _____, City: _____
State:_____ Zip Code:_____ Phone Number: _____

Witness' Signature:_____ Date: _____
Witness' Printed Name:_____