Print Form

Premier
OB/GYN of West Houston, L.L.P.

REQUEST FOR INFORMATION

ON THIS DATE _____I HERBY AUTHORIZE:

_____

NAME (YOUR PREVIOUS DOCTOR OR FACILITY; COMPLETE IN FULL) **PHONE NUMBER**

_____

STREET ADDRESS **CITY** **STATE** **ZIP**

TO FURNISH A COPY OF MEDICAL RECORDS, THIS MAY INCLUDE INFORMATION CONCERNING THE RESULTS AND/OR TREATMENT OF HIV, AIDS, MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE, OF THE PATIENT LISTED BELOW UPON MAKING REQUEST. I HEREBY RELEASE YOU, YOUR PHYSICIANS AND EMPLOYEES FROM LIABILITY FOR FOLLOWING THIS AUTHORIZED RELEASE FORM.

TO: MEDICAL RECORDS
PREMIER OB/GYN OF WEST HOUSTON, LLP
18300 KATY FREEWAY, STE. 315
HOUSTON, TEXAS 77094 PHONE 713-464-2100
FAX NO. 281-392-7911

.

****PLEASE COMPLETE ALL INFORMATION, INCOMPLETE OR ALTERED FORMS WILL NOT BE PROCESSED****

SPECIAL INFORMATION REQUESTED: PLEASE SPECIFY TIME PERIOD REQUESTED, PLEASE DO NOT SELECT ALL.

DATE OF SERVICE: FROM _____ TO _____ (PLEASE CHECK ONE)

- ☐ PAP SMEAR
- ☐ OFFICE NOTES
- ☐ LABS
- ☐ MAMMOGRAPHY
- ☐ OPERATIVE REPORTS
- ☐ PRENATAL RECORDS
- ☐ ALL RECORDS

THIS AUTHORIZATION IS VALID FOR 120 DAYS FROM THE DATE OF SIGNATURE.
ANY CHANGE IN AUTHORIZATION MUST BE IN WRITING.

REGARDING (PATIENT NAME)

SS NO. DATE OF BIRTH

ADDRESS

CITY, STATE & ZIP PHONE

PATIENT SIGNATURE
GUARDIAN, IF MINOR DATE

FOR OFFICE USE ONLY

DATE REQUESTED_____REQUESTED BY DR._____

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