The Women's Group

920 Medical Plaza Drive, Suite 380
The Woodlands, TX 77380
Phone 346-331-4575

Medical Release Form

Patient Name: _____ Date of Birth: _____
Address: _____ Telephone Number: _____
City, State, Zip: _____ SSN: _____

Medical records requested from:
Doctor: _____
Phone: _____ Fax: _____
Address: _____

Medical records sent to:
Doctor: _____
Phone: _____ Fax: _____
Address: _____
For the following purpose:
___ Medical care ___ Legal ___ Insurance ___ Other (details below)

___ Entire record
___ Operative/ Procedure report
___ Emergency Room records
___ Imaging/ Radiology
___ Laboratory

This authorization is valid for 180 days after the date it is signed unless it provides otherwise, or unless it is revoked, and covers only treatment for the dates specified above.

I, the undersigned, have read the above and authorize the staff at The Women's Group to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to extend that action has been taken in reliance up on it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

Signature of Patient/ Legal Guardian: _____

Date: _____ Relationship to Patient: _____