Women's Health Specialists of Dallas, P.A.
8160 Walnut Hill Lane Suite 200
Dallas, Texas 75231
Phone (214) 363-4421 Fax (214) 987-1657

<u>I hereby request that my medical records be released to:</u>

- ☐ Dr. Jonathan R. Brough, M.D.
- ☐ Dr. Angela M. Angel, M.D.
- ☐ Dr. Kavitha Blewett, M.D.
- ☐ Dr. Lisa G. Remedios, M.D.
- ☐ Roxanne E. Pero

Patient Name____
Patient Address ____
City____________________________State____________________Zip_______
Phone Number____
Social Security Number____
Date of Birth____

<u>I hereby request that my medical records be released from:</u>

Dr.____
Address____
City______________________State____________Zip_________________
Phone Number____
Fax Number____

I understand that this authorization may be withdrawn at any time in writing. This authorization will remain in effect for 90 days after I sign and date the form. Recipients of my information are forbidden from re-disclosure without my specific authorization. A facsimile may be utilized with the same effectiveness as the original.

Patient Signature: ________________________________Date_______________
Relationship if patient is a child_______________________________________