REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name _____ Date of Birth _____

Address _____ City _____ State_____ ZIP_____

Records Requested:
☐All Medical records ☐Gynecology only ☐Surgery Reports☐OB records only ☐Pathology/Lab Reports
☐Imaging/Ultrasound Reports ☐Billing Information ☐Other_____

I, the undersigned, do hereby authorize and direct you to:

[ ] Furnish records **TO** Personalized Women's Healthcare ***(we do not accept DVD/CD/thumb drives and will NOT create or click onto any link sent – please MAIL or fax (5 pages or less) medical records requested)***

[ ] Release records **FROM** Personalized Women's Healthcare
*****Complete medical records will only be available to be mailed or picked up.***

Physician Name: _____

Address _____

State _____ ZIP _____ Phone _____ Fax _____

Personalized Women's Healthcare
Berry A. Fleming, MD & Eric B. Jacoby, M.D.
3108 Midway Road, Suite 201
Plano, Texas 75093
Phone 972-473-2020 Fax 972-473-2077

I understand that my request will be processed within the timeframes set forth by state law or within 15 days, whichever is less. I understand that I am responsible for cost of copies.

Medical Records Request Fees

- Print – I understand that you may charge me a fee of $25 for the first 20 pages and 50c a page thereafter and mailing costs. (Texas Medical Board Rules Chapter 165)

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐Parent of minor ☐Guardian ☐ Other _____

SIGNATURE (patient or legal guardian) _____ Date _____