REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name ____ Date of Birth ______________________

Address ____ City ____________________ State______ ZIP__________

Which records are needed: ____

Reason for transfer/request: ____

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

[ ] Furnish records **TO** Personalized Women's Healthcare
[ ] Release records **FROM** Personalized Women's Healthcare

Physician Name: ____

Address ____

City ______________________State _____ ZIP __________ Phone ________________ Fax _________________

Check how records are to be received: Mail ________ Pick-Up ________

*******Complete medical records will only be available to be mailed or picked up.**

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)

PRINT NAME ____

SIGNATURE ____ **Date** ________________________