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

Please FAX records to 972-473-2077 OR mail to address below.

Please note we cannot accept any records on a disk or flash drive and will not click on or enter any link from which to upload medical records from dues to risk of uploading a virus or ransomware to our EMR.

Other Physician or Facility Name ____

Address ____

City _____________________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

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

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** ___________