

FEM Centre

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records to the person(s) or entity listed below.

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ DOB: _____

Release my protected health information FROM:

Physician: _____ Specialty: _____

Address: _____

City/State/Zip: _____

Request my protected health information TO:

Name: _____ Specialty: _____

Address: _____

City/State/Zip: _____ Phone: _____

Reason: _____

I understand that you will provide this information within 15 business days from receipt of request and payment of any fee for preparing and furnishing this information according to the rulings set forth by the Texas State Board of Medical Examiners.

Patient Signature

Date

HIV/AIDS: I consent to the release of any positive or negative test result of AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initials: _____ Date: _____