

FEM Centre

Joseph McWherter, M.D., P.A. and Associates
Medical Records Release Form

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Colleyville, TX 76034
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709 W. Leuda
Fort Worth, TX 76104
Ph: (817) 926-2511 Fax: (817) 924-0167

Patient Name (**please print**): _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Phone #: _____

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.

Release my protected medical information ____ **FROM** or ____ **TO** the following entity: (check one)

Physician: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Reason: _____

Please release the following:

- | | |
|--|---|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Diagnostic Reports |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Lab Work | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> X-Ray/Imaging Reports | |

Other: _____

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.

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: _____

This authorization will expire three hundred sixty five (365) days from the date of my signature unless I revoke the authorization prior to that time, or unless otherwise specified by date, event, or condition as follows:

Patient Signature

Date

Relationship to Patient or Legal Representative

Date