Heather Bartos, M.D., F.A.C.O.G
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8700 E. US Highway 380, Suite 300
Cross Roads, TX 76227(940) 365-9001

Authorization to Release Medical Records

Name: _____ DOB: _____

SSN#: _____ Phone: _____

Address: _____

Release my records **FROM:**

_____

_____

Phone: _____

Fax: _____

Release my records **TO:**

_____

_____

Phone: _____

Fax: _____

For the following purpose(s): **Transfer of care** **Continuation of care** **2nd Opinion**

Include: **( ) Complete Medical Records** **( ) Other:** _____

******I authorize be. Women's Health and Wellness, PLLC to use and disclose the protected health information specified above. I understand that this consent shall remain in effect for 180 days from the signed date unless revoked earlier by written notice. I understand there is a $25 fee for the first 20 pages and 50 cents for every page thereafter for records printed and given to me directly. I understand that, by law, this office has 15 business days to remit records. ******

Signature: _____ **Date:** _____

Staff Witness: _____

***This information is only intended for the individual/company listed above. If you are not the intended recipient, please destroy and call (940) 365-9001.**