

Cornerstone Ob-Gyn
16040 Park Valley Dr. Suite 222
Round Rock, Texas 78681
512-341-8001 Fax: 512-341-8011

MEDICAL RECORDS RELEASE

NAME: _____ (please print)
SSN#: _____ DOB: _____

Dear **Dr. Irvin** _____
Dr. Baylor _____
Dr. Choudhry _____

I authorize you and your office staff to provide a copy, summary, or verbal narrative of my medical records regarding the following concerns:

_____ **(Initial)** My entire medical file is requested.
_____ **(Initial)** Please release records regarding _____.
SPECIFY TREATMENT/CONDITION

_____ **(Initial)** I consent to the release of any positive or negative test results for HIV/AIDS infection, antibodies to AIDS or infection with any other causation agent of AIDS with the rest of my medical records.

I request my records for _____
_____ Transfer to another physician
_____ Copy to my Primary Care Physician
_____ Other (please specify) _____

TO: _____
Physician Name

Address

City, State, Zip code

Phone number Fax #

I understand the information may take up to 30 days from receipt of request. I am aware that a fee for preparing and furnishing this information may be charged to me.

Signed: _____ Date: _____
Signature of patient or legal guardian of patient