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

MEDICAL RECORDS REQUEST

NAME: ___________________________(please print)

SSN#: _______________________ DOB: _____________________

Dear: ___________________________

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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.

TO: Dr. _________________________
16040 Park Valley Dr. Suite 222
Round Rock, Texas 78681

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