Madhuri Gudipaty MD

ObGyn Specialists of Texas

3900 W 15th St. Suite 106

Tel: 972-867-7500

Fax: 972-867-7556

Medical Records Release Authorization

I ____________________ authorize the above listed physician, firm, or entity (Or its representatives or employees) to release for inspection and copying, any and all of the personal health information (PHI) listed below that pertains to my treatment, hospitalization or care on ________. Please include the following records for the purpose of continuing care.

Office Records	**Pap Smears**	**Laboratory Reports**
Pathology Reports	**Operative Reports**	**Hospital Reports**

Patient Name: ____________________________________ **DOB:** _______________________

Address: ____

City: ___________________ **State:** _________________________ **Zip:** ____________________

Phone No: ________________________________ **SSN:** ________________________________

Medical Records are requested from:

Dr: ____

Address: ____

City: ___________________ **State:** __________________________ **Zip:** ___________________

Phone No: ____________________________ **Fax No:** _________________________________

Signature of patient or legal representative: ____