Gregory L. Eads, M.D., FACOG
Joanne Evans-Lewis, MSN,WHNP
1120 Medical Plaza Drive
Suite 200 The Woodlands, TX 77380
Phone: 832-813-0979
Fax: 832-813-0984

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: ______________________

Patient Name: ________________________________ DOB: ______________

SS# ____

Purpose / need for information

☐ Application for Insurance ☐ Changing Physicians ☐ Personal

☐ Regarding Insurance Claim ☐ Specialist

SPECIFIC RECORDS REQUIRED:

☐ Office Notes:

☐ Laboratory Reports

☐ X-ray reports ________________

(Specify if necessary)

OTHER:

☐ ______________________________

☐ ______________________________

☐ ______________________________

Records Requested From:

____

____

____

Records Sent To:

____

____

____

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to me during the period:

FROM: __________________________ TO: ______________________________

I understand that this information will expire 90 days from the date of signature below or when acted upon, whichever event occurs first, I hereby release the following addressee, its employees and appointed representatives from any and all liability that may arise from the release of information as I have directed.

____

Signature of Patient/Guardian