WESTERN
Gynecological + Obstetrical Clinic
Total Women's Health Care

Western Gyn/Ob
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REQUEST FOR RECORDS RELEASE

Name of Patient:		DOB:
Social Security #:	Fax #:	
Home Phone:	Work Phone:	
Address:	City:	
	State:	Zip:

I HEREBY AUTHORIZE (Where records are being requested from):	
Address:	
Phone #:	Fax #:

TO RELEASE MY RECORDS TO (Where records need to be sent):	
Address:	
Phone #:	Fax #:
Date records are needed by:	

THIS RELEASE IS VALID FOR 90 DAYS ONLY. Most requests will be processed in 5-7 business days. I understand all copying fees will be billed to my account and that I am responsible for payment.

Patient Signature:	Date:

PLEASE CHECK ONE	**OFFICE USE:**
☐ Transferring care	Received By:
☐ Last 5 years	Date Mailed:
☐ Records concerning: _____	Date Faxed:
☐ Records from date(s) of service: _____	Date Pt. Picked Up:
☐ Labs (For dates of service): _____	Sent By:
☐ Other: _____	