Women's OB/Gyn Center

5119 Fairmont Parkway • Pasadena, TX 77505

Tel (281) 991-7603 • Fax (281) 991-7675

Last Name______________________ **First Name**______________ **MI:**__________

DOB:____________________ **SSN:**_____________________

Physicians Name:______________________ **Phone:**______________________

REQUEST TO RELEASE MEDICAL RECORDS TO:

- **DEYA DAFASHY, M.D.**
- **NICOLE GILLMAN, M.D.**

FAX TO RECORDS TO:
281-991-7675
OR
MAIL TO:
P.O. BOX 890827
HOUSTON,TX 77289-0827

TYPE OF INFORMATION REQUESTED FOR CONTINUED CARE:

- **CONSULTATION, HISTORY & PHYSICAL, AND PROGRESS NOTES**
- **LABORATORY STUDIES**
- **IMAGE STUDYS**
- **OTHER**____

HIV/AIDS: I CONSENT TO RELEASE ANY POSITIVE OR NEGATIVE RESULTS FOR HIV OR AIDS INFECTION, ANTIBODIES TO AIDS, OR INFECTION WITH ANY OTHER CAUSATIVE AGENT OF AIDS, WITH THE REST OF MY MEDICAL RECORDS. **INITIALS:**_______ **DATE:**__________

THIS AUTHORIZATION IS VALID UNTIL THE 180TH DAY AFTER THE DATE IT IS SIGNED UNLESS IT STATES OTHER WISE, NOT TO EXCEED 24 MONTHS, OR UNLESS IT IS REVOKED IN WRITING.

I, THE UNDERSIGNED, HAVE READ THE ABOVE AND AUTHORIZE THE STAFF OF THE ABOVE NAMED OFFICE TO DISCLOSE SUCH INFORMATION AS HEREIN CONTAINED. I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING ANY TIME EXCEPT TO THE EXTENT THAT ACTIO HAS BEEN TAKEN IN RELIANCE UPON IT. I UNDERSTAND THAT WHEN INFORMATION IS USED OR DISCLOSED PERTAINING TO THIS AUTHORIZATION, IT MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED. I HEREBY RELEASE THE ABOVE NAME FACILITY FROM ALL LIABILITY AND DAMAGES RESULTING FROM THE LAWFULL RELEASE OF MY PROTECT HEALTH INFORMATION.

______________________________ ______________________________
SIGNATURE OF PATIENT/GUARDIAN DATE SIGNED