Pearl OBGYN

3252 E Douglas Ave. Ste 101
Wichita, Ks. 67208
(316)687-3275

Medical Records Release Form

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ DOB: _____

Company (Transferring From): _____

Address: _____

Telephone: _____ Fax: _____

I authorize the release of my medical records or other health information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment during the period of _____ to _____; to be sent to the following person or company.

Company: ___Pearl OB/Gyn_____

Address: ___3252 E Douglas, Ste 101, Wichita, KS 67208_____

Telephone: __316-687-3275_____ Fax: __833-907-2276_____

Client Signature: _____ Date: _____

This authorization if valid until : _____