PEARL OBGYN

Damen Hershberger, M.D.
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3252 E Douglas, Ste 101, Wichita, KS 67208
Phone: (316) 687-3275
Fax: (833) 907-2276

Medical Records Release Form

Patient Name: ____

Address: ____

City: ________________________ State: _____________________ Zip Code: ___________

Telephone: __________________________ DOB: ______________________________

Company: ___Pearl OB/Gyn____

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

Telephone: __316-687-3275_______________ Fax: __833-907-2276_____________________

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: ____

Address: ____

Telephone: __________________________ Fax: _______________________________

Client Signature: _______________________________ Date: _______________________________________

This authorization if valid until : __________________________