GOG | GEORGETOWN OB-GYN

John Sherman, MD Vincent Sherman, MD Kelly Montiville, MD
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AUTHORZATION TO RELEASE MEDICAL RECORDS

From: _____

Telephone: _____ **Fax:** _____

Address: _____

To: _____

Telephone: _____ **Fax:** _____

Address: _____

This letter will Authorize the above physician, provider or facility to provide a copy, summary or narrative of my medical records as indicated by the checkmarks below, or otherwise release confidential information.

_____Complete Record

_____Record of Care from _____ to _____

_____Other, specify: _____

_____Confer with other person orally about information in my medical records.

**I consent to the release of any positive or negative test results for HIV infection included in my medical record unless otherwise specified above.

**I consent to the release of any information pertaining to mental health included in my medical record unless otherwise specified above.

I understand that this information will be provided within 15 days from receipt of request per Medical Practice Act of Texas State Board of Medical Examiners and that a fee for preparing and furnishing this information may be charged.

The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under 1) Aid to Families with Dependent Children, b) Medicaid, c) Medicare, d) Supplemental Security Income, and e) Federal Old Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Signed: _____ Date: _____

Printed Name: _____ DOB: _____