REQUEST FOR INFORMATION

Fax to 281-579-9914
ELITE WOMEN'S CARE CENTER, PA
18400 Katy Freeway, Ste.400, Katy, TX 77094
Office 281-579-9900

By signing this form, I hereby provide authorization for release of my confidential health information to Elite Women's Care Center, PA. I consent to the release of my medical records, including information regarding HIV/AIDS, Mental Health, Alcohol and/or Drug Abuse to the aforementioned Elite Women's Care Center, PA. My authorization releases the provider of this information from any liability for complying with this authorization.

_____ _____
Patient / Guardian Authorization Signature Date of Authorization

PLEASE COMPLETE REQUESTED INFORMATION IN ITS ENTIRETY

SPECIAL INFORMATION REQUESTED: SPECIFY TIME PERIOD REQUESTED (Please Check One)

Physician Name:_____ **Phone#**_____

Physician Address:_____

DATE OF SERVICE: FROM - _____ TO _____

___HISTORY & PHYSICAL ___PATHOLOGY ___ALL RECORDS

___PROGRESS NOTES ___OPERATIVE REPORTS ___IMAGING

___LABORATORY RESULTS ___PRENATAL RECORDS

Patient Name: _____ SS No._____

Address:_____

City, State, ZIP:_____