FEM Centre
Joseph McWherter, M.D., P.A. and Associates
Medical Records Release Form

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Colleyville, TX 76034
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709 W. Leuda Street
Fort Worth, TX 76104
Ph: (817) 926-2511 Fax: (817) 924-0167

Patient Name (**please print**): _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Phone #: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records to the person(s) or entity listed below:

☐ I authorize FEM Centre to **RELEASE** information to:	OR	☐ I authorize FEM Centre to **OBTAIN** information from:
Name of Provider or Facility		Name of Provider or Facility
Address		Address
City, State, Zip Code		City, State, Zip Code
Phone#		Phone#
Fax #		Fax #

PURPOSE FOR THIS REQUEST (REQUIRED): ☐ Transfer of Care ☐ Social Security/Disability ☐ Continuing Medical Care ☐ Legal purposes ☐ Second opinion ☐ Personal Request (Fees apply for personal requests)

DATES OF RECORDS REQUESTED (REQUIRED): _____ TO _____

RELEASE THE FOLLOWING (REQUIRED): ☐ Office Notes ☐ Diagnostic Reports ☐ X-Ray/Imaging Reports ☐ Lab Work ☐ Pathology Reports ☐ Medication List ☐ Other: _____

HIV/AIDS: I consent to the release of any positive or negative test result of AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initials: _____

Alcohol/Drug Abuse/Mental Health: I consent to the release of any records containing alcohol/drug abuse and/or mental health records with the rest of my medical records. Initials: _____

This authorization will expire ninety (90) days from the date of my signature unless I revoke the authorization prior to that time in written form, or unless otherwise specified by date, event, or condition as follows.

I understand that:

- *Authorizing the disclosure of this health information is voluntary. If I have questions about disclosure of my health information I can contact the authorized individual or organization making disclosure.*
- *There **may be** a charge for the requested records, $25 for the first 20 pages of medical records copied and $0.50 for each additional pages plus mailing cost. Records may be sent via USPS mail or by fax.*

_____ _____
Patient Signature Date

_____ _____
Relationship to Patient Date