

Hill Country OB/GYN Associates
For All Phases of a Women's Life

Release of Medical Records

Records requested from:

Name of Doctor/Facility: _____

Address: _____

Telephone #: _____

Patient Name: _____

Date of Birth: _____ Social Security Number _____

I, _____ hereby request and authorize the release of my
medical records concerning (check all that applies):

- _____ Pap smear results
- _____ Lab results
- _____ Gynecological Exams
- _____ Prenatal records
- _____ Ultrasound/X-ray results
- _____ All Records
- _____ Other

Please send the above requested records to the attention of:

Margaret R. Landwermeyer, MD, F.A.C.O.G

Ana M. Eduardo, MD, F.A.C.O.G

Lisa B. Schneider, MD, F.A.C.O.G.

Chris Hart, MD

Signature _____

Date _____

Witnessed by _____