

KATHRYN E. WHITE, M.D.

Gynecology & Infertility

MEDICAL RECORDS RELEASE FORM

TO:

I, _____ Date of Birth: _____ request
(Print patient's name or guardian)

and authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information.

- Complete records
- Records of care from the following dates: _____ to _____
- Records concerning the following conditions: _____
- Other, please specify: _____

Release to the following person(s):

Name: _____
Street: _____
City: _____ State: _____ Zip: _____

The reasons or purposes for this release of information are as follows:

I understand that information in my health record may include information relating to:
1) AIDS/HIV test results, infection status or treatment information; 2) sexually transmitted disease; 3) treatment for alcohol or drug abuse; 4) behavioral and mental health services. I
AUTHORIZE THE DISCLOSURE OF THIS INFORMATION EXCEPT AS FOLLOWS:

Patient's Signature or Signature of Parent or Legal Guardian Date

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Texas State Board of Medical Examiners.