John D. Bertrand
M.D., F.A.C.O.G

Jeffrey M. Thurston
M.D., F.A.C.O.G

Jane E. Nokleberg
M.D., F.A.C.O.G

Julie M. Hagood
M.D., F.A.C.O.G

WALNUT HILL
Obstetrics & Gynecology Associates

8305 Walnut Hill Lane, STE 100
Dallas, TX 75231
Phone: (214)363-7801
Fax: (214)635-3397

Lauren A. Murray
M.D., F.A.C.O.G

Sooyeon Choi
M.D., F.A.C.O.G

Lauren Battley
M.D., F.A.C.O.G

Sarah Brewer
M.D., F.A.C.O.G

I hereby grant my permission for release of medical information relating to my care from and to the following parties:

Patient Name: _____DOB: _____

Address: _____City_____Zip_____

Previous/Current Doctor: _____ Address: _____

Phone: _____ Fax: _____

The Purpose of this release of information is to provide continuity of my care, for processing insurance claims, or to meet another specific desire of mine. I specify that this release includes:

1. Entire Chart – This information might include: HIV Testing and/or AIDS Treatment, Substance Abuse Treatment and/or Rehabilitation and Psychiatric Testing and/or Treatment.

OR

2. Specific Information to be released: Please specify exactly what you would like submitted (i.e., labs, mammogram results, pathology reports)

_____

_____

_____

I understand that this authorization may be withdrawn at any time in writing. This authorization will remain in effect for 90 days after I sign and date the form. Recipients of my information are forbidden from re-disclosure without my specific authorization. A facsimile may be utilized with the same effectiveness as the original. I also understand there may be a charge for the processing of this request. Requests for medical records may be subject to a $27 fee.

Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____ Phone Number :_____