Stanley F. Franklin, M.D.
Center for Gynecology
541 W. Main St., Ste. 101
Lewisville, TX 75057
Phone: 972-420-8585 Fax: 972-221-4892

MEDICAL RECORD RELEASE OF INFORMATION

I,_____DOB:_____SS#_____,
Request and authorize **Dr. Stanley F. Franklin**, to release the medical record of the above named patient:

_____ALL HEALTH CARE INFORMATION **INCLUDING** INFORMATION RELATING TO HIV/AIDS TESTING, SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC DISORDERS/MENTAL HEALTH OR DRUG AND/OR ALCOHOL USE.

_____ALL HEALTH CARE INFORMATION **EXCLUDING** INFORMATION RELATING TO HIV/AIDS TESTING, SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC DISORDERS/MENTAL HEALTH OR DRUG AND/OR ALCOHOL USE.

_____ALL HEALTH CARE INFORMATION RELATING TO THE FOLLOWING TREATMENT CONDITION OR DATES OF TREATMENT: _____

_____

REASON FOR REQUEST: _____

MEDICAL RECORDS TO BE: MAILED FAXED PICKUP

TO: **Name of Recipient:** _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

SIGNATURE OF PATIENT AND/OR AUTHORIZED REPRESENTATIVE:

_____ DATE: _____

This release expires 90 days after the date it is signed.

MEDICAL RECORDS REQUEST

DOCTOR: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

YOU ARE HEREBY AUTHORIZED TO RELEASE TO:

STANLEY FRANKLIN M.D., P.A.
CENTER FOR GYNECOLOGY
541 W. Main St., Ste. 101
Lewisville, Texas 75057
Ph. 972-420-8585 Fax 972-221-4892

Any information, including diagnosis and records of my treatment rendered to me during the period listed below:

NAME OF PATIENT (Please Print) DATES TREATED

_____ _____

Signed: _____ Witness:

Address: _____ _____

City: _____

State/Zip: _____ Date: _____