

Centennial OB/GYN, P.A.  
5757 Warren Pkwy. Suite 210  
Frisco, Texas 75034  
Phone (972) 731-6565  
Fax (972) 731-6570

Patient: Name \_\_\_\_\_ DOB \_\_\_\_\_

Previous name which chart may be listed \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Cell \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

Who has the information you would like released?

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Where will the records be sent?

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Information to be released:

- Office notes
- Lab results
- Pap smear
- Operative notes
- Prenatal records
- Other (please specify) \_\_\_\_\_
- All records

Please let us know the reason you are requesting your records:

- Insurance change
- Move
- Other \_\_\_\_\_
- Second opinion
- Disability

I understand that this authorization will be in effect for 12 months unless cancelled by me in writing and that cancellation will take effect when the provider receives my notice in writing.

Patient signature (or legal guardian if patient is a minor) \_\_\_\_\_