ASH DABBOUS, MD, FACOG
FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY

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MEDICAL RECORDS REQUEST FORM

This authorizes you:

_____

Phone # _____ Fax # _____

To provide a copy, summary, or narrative of my medical records (as indicated by the checkmarks below, or otherwise release confidential information.

____ complete record

Records of care from following dates _____ to _____

Records concerning the following conditions: _____

Other, please specify: _____

I do ____do not ☐ check appropriate choice, authorize this information to be faxed.

The date, extent or condition upon witch this authorization expires is _____ is not to exceed 24 months. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 90 days from the date below.

Release to following person:

Dr. Ash Dabbous, M.D.

335 E. Sonterra Blvd. Suite 170, San Antonio, TX 78258

The reason for release of this information are as follows:_____

Patient Signature: _____ Date: _____

Print Name:_____ DOB :_____

I understand that you will provide this information within 30 days from receipt of request