WOMEN'S WELLNESS INSTITUTE OF DALLAS
Wesley Anne Brady, M.D.
MEDICAL DIRECTOR

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (please print):

Name: ____________________________________ Date of Birth: ___________________
Address: ____
City: __________________________ State: ________ Zip Code: ____________________
Patient Phone: ___________________________

REQUESTING MEDICAL RECORDS FROM THE FOLLOWING:

Physician Name: ________________________________
Facility: ____
Phone: ________________________
Fax: __________________________

PLEASE SEND THE FOLLOWING RECORDS:

( ) Operative Reports
( ) Laboratory Reports
( ) Office Notes
( ) All Records

By my signature I authorize release of medical records to Wesley Anne Brady, MD of the Women's Wellness Institute of Dallas.

Signature: ____ **Date:** __________________________

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