Authorization for Release of Medical Records

Date _____

Patient Name _____ Patient Phone # _____

Social Security Number _____ Date of Birth _____

Patient Address _____

_____

I hereby request the release of my medical records **to**:

Name of Patient _____

Request **from**:

Dr. Janetta Proverbs
Blue Valley Women's Care
9375 West 75th Street
Overland Park, KS 66204
Phone (913) 642-7000
Fax (913) 642-7020

Choose one:

☐Email records to_____
(your email address)

☐Fax records to_____
(your fax number)

Patient Signature _____

Print Patient Name _____

Reports Requested:

Operative Report _____ Obstetrical Reports _____

Discharge Summary _____ Mammogram Reports _____

Pathology Report _____ Sonogram Reports _____

Previous Pap Smear _____ Complete Records _____