WOMEN'S SPECIALTY CENTER

Dallas, TX
(214) 942 - 3100
contact@wscdallas.com
www.womens-specialty-center.com

REQUEST OF MEDICAL RECORDS

Date: _____/_____/_____

To: ______________________________________ Fax: _______________________________
Physicians Name (print)

____
Address

____
City State Zip Code

I hear by request my medical records to be released to
Women's Specialty Center.
Please send only those records that contain information on

____
____
____
____

__________________________ __________________________
Patient Name DOB (mm/dd/yyyy)

____
Address

____
City State Zip Code

__________________________ __________________________
Signature Date (mm/dd/yyyy)