



Dedicated to Women
OB-GYN

MEDICAL RECORD RELEASE REQUEST

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I authorize _____
Releasing Physician Name

Physician's Phone Number Physician's Fax Number

to release my medical information, including the diagnosis and records, of any treatment or examination rendered to me during the period from _____ to _____.

These records are to be released to:

**Dedicated to Women OB-GYN
540 S. Governors Ave., Suite 201
Dover, DE 19904
302-674-0223**

Print Name: _____

Date of Birth: _____

Signature: _____

Date: _____

Email Address: _____

Witness: _____
Dedicated to Women OB-GYN Employee

Please Note: The physician's office providing your records may charge for this service. It is the patient's responsibility to verify that her records have been sent to Dedicated to Women OB-GYN prior to her appointment with a Dedicated to Women OB-GYN provider.