OMEGA WOMEN'S CENTER, LLC

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REQUEST FOR RELEASE OF MEDICAL RECORDS

To: ____
Physician or Hospital Name

____
Address

____
City State Zip Code

I Hereby authorize that my medical records be released to:

OMEGA WOMEN'S CENTER
1801 University Drive
Suite 201
Coral Springs, FL 33071

Please include the following information:

- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Pathology Reports
- ☐ Labor & Delivery, Prenatal Records
- ☐ Office Records

Reason for release:

- ☐ Insurance change
- ☐ 2nd opinion or consultation
- ☐ Transferring to another physician
- ☐ Moving out of area

______________________ ____________ ______________
Patient's Name (print) DOB SS #

____
Patients' name at time of procedure / Date of Procedure

______________________ / ______________________ ____________
Patient's Signature Witness Date

____ ____________
Signature of employee releasing records Date