SUGARLAND WOMEN'S HEALTH CENTER	14090 Southwest Freeway, Suite 101 Sugar Land, TX 77478 Office 281.313.1193 Fax 281.313.1194

REQUEST FOR MEDICAL RECORD

To:

Medical Facility:_____

Address: _____

City, State, Zip:_____

I hereby authorize the release of all my medical records and test results including HIV test results, in your possession regarding my medical condition. Please send of fax record to:

Dr. Cuong M. Nguyen
Sugarland Women's Health Center
14090 Southwest Freeway, Suite 101
Sugar Land, TX 77478
Fax: 281.313.1194

I release you from liability for following this request.

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____