

REQUEST FOR RELEASE
OF
MEDICAL RECORDS

(Please fill out and fax to your physician upon receipt of this release form)

TO: _____

Physician's Name

Address

City

State

Zip

Fax #

I hereby request that my medical records be released to:

J. MICHAEL PUTMAN, M.D. & ASSOCIATES
ADVANCED GYNECOLOGIC ENDOSCOPY

3900 Junius Street, Ste 610
Dallas, Texas 75246
(214) 823-2692
(214) 887-8244 FAX

Patient's Signature: _____ Print Name: _____ Date: _____

Husband's Signature: _____ Print Name: _____ Date: _____

(Husband's signature is required if you are requesting male factor test results, such as Semen Analysis)