FERTILITY CENTER
OF DALLAS

J. Michael Putman, MD, PA
and Associates

This form can be used for you to send to your OB/GYN or previous treating physician to request your medical records.

Medical Records Release Authorization

Physician Name: _____

Address: _____

Fax#: _____

I hereby authorize and request the release of medical records to:

J. Michael Putman, MD, PA
Fertility Center of Dallas
Baylor Medical Pavilion
3900 Junius St., Ste. 610
Dallas, TX 75246
214-823-2692
214-887-8244 fax

Please forward my complete medical history records in your possession regarding my illness and/or treatment.

Name: _____ DOB: ____/____/____

Address: _____

Signature: _____ Date: ____/____/____