



Dear \_\_\_\_\_:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

- \_\_\_\_\_ Complete record
- \_\_\_\_\_ Records of care from \_\_\_\_\_ to \_\_\_\_\_ only
- \_\_\_\_\_ Records of care concerning the following condition(s)  
\_\_\_\_\_
- \_\_\_\_\_ Other. Specify:  
\_\_\_\_\_

Release of records and information in my medical record to the following person(s):

Born Again Obstetrics & Gynecology / Flor A Limas, MD  
3220 Buddy Owens Blvd, Suite 300  
McAllen TX, 78504  
Phone Number: 956-627-5245  
Fax Number: 956-627-5246

The reasons or purposes for this release of information are:

- A) Continuity of medical care.
- B) Other \_\_\_\_\_

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

Initials \_\_\_\_\_ Date \_\_\_\_\_

I understand that you will provide this information within 15 business days from receipt of request.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient or person legally authorized to consent on patient's behalf)