BORN AGAIN
OBSTETRICS & GYNECOLOGY

Dear _____ (Doctor/Facility):

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 **(check one)**:

_____ 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 **(circle one)**:

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: _____

Signature:_____Date: _____

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