Doctors for Women
8001 Youree Drive, Suite 900
Shreveport, Louisiana 71115
Ph (318) 797-0101
Fax (318) 797-0010

Patient Name (full name) _____

Birthday and Age_____

Social Security No._____

Address_____

_____

Phone Home_____Work_____

The undersigned hereby authorizes and requests

_____, M.D.

_____

to provide Dr. Jacque T. LaBarre and/or Dr. M. Cecilia Bellmann
of Doctors for Women, LLC at the above address with access to my medical / hospital records for the purpose of review and examination and further request you provide such copies thereof as may be requested.

The foregoing is subject to the following time period:

Covering records for the period from _____to_____

There are no limitations placed on the above dates regarding history or illness,

or diagnostic and therapeutic information, including treatment for alcohol and

drug abuse, or treatment of any sexually transmitted disease including HIV.

Signature_____Date_____