

**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 _____