NuWave
Women's Health

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

Physician or Hospital Name

_____

Address City State Zip Code

(_____)_____-_____(_____)_____-_____

Phone Number Fax Number

I, _____ Date of birth: _____ hereby request and authorize copies of my complete/ partial medical records including HIV test results to be released to:

Dr. James Duerkes, D.O., F.A.C.O.G
NuWave Women's Health, LLC
700 N. Hiatus Road, Suite 209
Pembroke Pines, FL 33026

Patient's Signature: _____ Date: _____