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 _____ DOB _____ 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, L.L.C
700 N. Hiatus Rd, Suite 209 Pembroke Pines, FL 33026
TEL: (954)951-5523 FAX: (866)868-7025

_____ _____
Patient's Signature Date