

Dr. Yolande Hackney & Dr. Leslie Simmons

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MEDICAL RECORDS REQUEST FORM

DATE:	
physician below to be released and the medical records to be released	, authorize and request a copy of my medical records from the I sent to the Metropolitan Women's Group, LLC. I understand that may contain information related to HIV status, AIDS, sexually or drug use, or mental health services and I hereby authorize the
Physician Name:	Patient Name:
Address:	Address:
Phone:	Birthdate:
Fax:	Social Security#:
	Patient Signature:

Please mail or fax a copy of the records to the Greenbelt location at the address below:

Metropolitan Women's Group, LLC 7701 Greenbelt Road, Suite 503 Greenbelt, MD 20770 301-513-0200 301-513-0555 (Fax)

Thank you.