



Eugene J. Louie-Ng, MD, FACOG
Michael S. Liao, MD, FACOG

RECORD REQUEST

Patient Name: _____ Date of Birth: _____ SSN: _____

Patient Address: _____
Street

City, State, Zip

Phone Number: _____

I authorize the release of the following records from _____
to Lake Manassas Women's Health Associates.

_____ All Medical Records

_____ Obstetrical Records Only _____ Lab and Radiology Reports Only

Only the following specific information: _____.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Authorization Expires

Witness