

Medical Records Release

I hereby authorize:

To release to:

North Texas Family Medicine
1340 North Hwy 377 Suite 110
Pilot Point, TX 76258
Phone# (940) 686-0860
Fax # (940) 686-5834

The information contained in the medical record of:

Patient: _____ D.O.B. _____

Information Requested:

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Progress / Clinical Record
<input type="checkbox"/> Discharge Summary Studies	<input type="checkbox"/> Lab/ X-Rays/ Diagnostic
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Psychiatric Information
<input type="checkbox"/> The Complete Record	<input type="checkbox"/> Other _____

For the purpose of:

<input type="checkbox"/> Follow Up Care	<input type="checkbox"/> Personal Concerns
<input type="checkbox"/> Legal Needs	<input type="checkbox"/> Other _____

Date: _____

Patient's Signature / Legal Guardian

If the above named person is under age 18 or has a legally appointed guardian, the designated legal guardian must sign this release. Proof of guardianship may be required.