FAMILY MEDICAL ASSOCIATES

MEDICAL RECORD RELEASE FORM

Dear Dr. _____

This letter will authorize you to provide a copy, summary or narrative of the medical records of _____ (as indicated by the check mark below):

_____ Complete record

_____ Records of care from _____ to _____ only.

_____ Records of care concerning the following condition(s):

_____

to the following person:

_____
NAME

_____
ADDRESS

_____
CITY STATE ZIP

The reasons or purposes of this release of information are as follows:

_____

_____

I understand that you will provide this information within thirty (30) days and that a reasonable fee for furnishing this information may be charged.

Signature of patient or person legally authorized to consent on patient's behalf:

_____ DATE: _____
Signature

_____ _____ _____
Print Name Date of Birth SS#

1175 DIANE CIRCLE LEWISVILLE, TEXAS 75067 TELEPHONE (972) 436-7531