Medical Records Release

I hereby authorize: ______________________________
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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:

_____History and Physical

_____Progress / Clinical Record

_____Discharge Summary

_____Lab/ X-Rays/ Diagnostic Studies

_____Operative Report

_____Psychiatric Information

_____The Complete Record

_____Other_______________

For the purpose of:

_____Follow Up Care

_____Personal Concerns

_____Legal Needs

_____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.