Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records or a summary or narrative of my protected health information to the physician, facility, or entity listed below.

Name: _____ DOB:_____

The information you may release subject to this signed release form are as follows:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Record
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (please specify):

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

TO: FROM:

Advocate Primary Care
370 State Highway 121 Ste. 100
Coppell, TX 75019
Phone: 972-382-5761
Fax: 855-592-2117

Name: _____
Address: _____
_____
Phone: _____
Fax:_____

_____ _____
Patient Name Patient DOB

_____ _____
Patient/Legal Guardian Signature Date