Fax: 469-587-8440 ***Location (check one):***

☐ INJURY 1 of DALLAS 9262 Forest Lane, Suite 101 Dallas, TX 75243	☐ INJURY 1 of FORT WORTH 3304 SE Loop 820, Ste A Fort Worth, TX 76140	☐ INJURY 1 of WACO 185 Eastgate Plaza Waco, TX 76705

Medical Record Release & Request

To obtain and/or release your medical records from/to another medical provider/facility, receive a copy for yourself or your attorney, or from another party, you must complete this form. Please fill it out completely and return it to us. If you have any questions, please do not hesitate to contact our office.

I, ___________________________________(Patient Name)____________________(SSN), ___________, (DOB)

Hereby authorize the release of the following information:

- Most recent exam and tests
- All of my Medical Records, (including but not limited to treatment notes, reports or studies that were performed at your office)
- Job duties/requirements
- Other: ____

Please forward the documentation to:

Name of Provider: ____

Address of Institution or Provider: ____

I understand that the records are for the care, treatment or medical services provided to me, and retained by you are confidential and are being disclosed for the purpose of:

- Continuation of Care
- Litigation

I further understand that without this authorization, the provider/facility would not be permitted to disclose this information, as indicated by law.

I recognize that I may revoke this consent at any time except to the extent that the information has already been released in reliance of this form. If not revoked, this consent will expire one year from the date signed.

I agree further not to sue or hold the provider of the information, its employees or agents, responsible for any issues, claims or causes of action arising out of the release of information in conformance with the terms of this release.

_______________________ ____

Date **Patient Signature (or Parent/Guardian if Patient is a Minor)**

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