☐ **Plaza Medical Centre**
700 N Pearl St, Suite N208
Dallas, TX 75201
Tel: (214) 999-9355

☐ **Griego Family Medical Centre**
2701 S Hampton Rd, Suite 101
Dallas, TX 75224
Tel: (214) 330-9221

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION:

Name: ____________________ **Date of birth** ____________________

Address: ______________________________ **Apt:** __________

City: ____________________ **State:** __________ **Zip**: __________

Phone: ____________________ **SSN#:** ____________________

RELEASE OF MEDICAL RECORDS FROM:

Name: ____

Address: ______________________________ **Apt:** __________

City: ____________________ **State:** __________ **Zip:** __________

Tel: ____________________ **Fax:** ____________________

RELEASE OF MEDICAL RECORDS TO:

Name: ____

Address: ______________________________ **Apt:** __________

City: ____________________ **State:** __________ **Zip:** __________

Tel: ____________________ **Fax:** ____________________

Please send a copy of the following medical records only:

- ☐ Lab Reports and Lab Results
- ☐ Diagnostic Reports
- ☐ Consultation Reports
- ☐ Immunization Records
- ☐ Last Clinic Visit Note
- ☐ Entire Record

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient Signature: ______________________________ **Date:** __________