

Release of Medical Information

I, \_\_\_\_\_, hereby authorize and request the release of:  
(Patient Name) (Circle One of the following you are requesting)

\*My complete medical records

\*Information concerning treatments or illness during the period of \_\_\_\_\_ to \_\_\_\_\_

\*A letter or records containing medical information as described: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Information:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other: \_\_\_\_\_

SS# (if required): \_\_\_\_\_

\*Please Circle on of the following on Sending To or Retrieving From

Would you like these records Mailed or Faxed? (Circle One)

(Sending to or Retrieving from)

(Sending to or Retrieving from)

Bander Family Medical

Doctor/Other: \_\_\_\_\_

791 S. HWY 78

Address: \_\_\_\_\_

Wylie, TX 75098

\_\_\_\_\_

Office #972-442-4888

Office #: \_\_\_\_\_

Fax # 972-442-4970

Fax #: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Patient/Guardian) Today's Date: \_\_\_\_\_

\_\_\_\_\_  
(Relationship to Patient)