info@northdallaspcp.com
www.northdallasprimarycaredoctors.com

RELEASE OF INFORMATION REQUEST

Fax Records Only

1. I hereby authorize _____ to release Medical Records to **North Dallas primary Care Doctors PLLC**

Patient Name (please print)	Birth Date
Date of Service	Social Security Number

2. Information requested:

_____Entire chart	_____Short Stay Form
_____Emergency Room Records	_____History & Physical
_____Computer printed face sheet	_____Discharge Summary
_____Operative Report	_____Consultation Report
_____Pathology Report	Physician: _____
_____Physicians Orders	_____Physicians Notes
_____Lab Results	_____Nurse Notes
_____Radiology Report(s)	_____EKG's
_____Other, Specify:_____	

3. There are no limitations placed on dates, history of illness or diagnostic and therapeutic information. This includes any treatment of ALCOHOL/DRUG ABUSE/AIDS, or PSYCHIATRIC TREATMENT. SIGNER TO INITIAL FOR APPROVAL OF THIS TYPE OF RELEASE: X_____

4. The above information is requested for the following purpose only:

5. I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance on it and that in any event this authorization will expire 180 days from the date of my signature.

6. I hereby authorize that a photocopy of fax copy of this authorization form will be fully acceptable as an original

Signature of Patient	Date
Witness	Relation to Patient

7589 Preston Road,# 600, Frisco,TX 75034 Phone: 214-705-3728 Fax: 214-308-9464