Medical Records Release Form

By signing this form, I authorize the Dr. and legal representative of medical records named below to release my confidential health information about me by releasing a copy of my medical records, or narrative of my protected health information to the entity named below

Release records from :_____

_____

Patient Name:_____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

Physician: Prime Internal Medicine Associates ph. 469-587-8480, fax 469-729-6691

Street: 12200 Park Central Drive, Suite 189

City: Dallas, Texas 75251

The reason or purpose for this release of information is as follows:

_____

Patient signature (or parent, guardian or legal representative)

_____

Date:_____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.