MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

Patient Name: ___________________________________ Date of Birth: ____________

The information you may release subject to the signed release form is as follows:

Complete Records	History & Physical	Progress Notes
Care Plan	Lab Reports	Radiology Reports
Pathology Reports	Treatment Record	Operative Reports
Hospital Reports	Medication Record	Other (Please specify below)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Mary Grace Bridges, MD
601 N Tom Green Ave, Suite B
Odessa, TX 79761
Fax: (833) 908 – 2112

____ ___________________

Printed Name Date

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Signature of Patient/Guardian/Power of Attorney/Healthcare Surrogate