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Authorization to Release Medical Records

THIS AUTHORIZES YOU TO PROVIDE A COPY, SUMMARY OF MY MEDICAL RECORDS
(AS INDICATED BY THE CHECKMARKS).

() Records concerning the following condition(s): () Records of care for the following dates:

() Complete Medical Records.

() Other: _____

Release My Records From:

Release My Records To:

Phone: (_____) _____

Phone: (_____) _____

Fax: (_____) _____

Fax: (_____) _____

Reason for release. Please circle one:

Transferring doctor / 2nd Opinion / Specialists / Moving Away / Other, please explain below.

Name: _____ **DOB:** _____ / _____ / _____

SSN#: _____ **Phone:** _____
(_____) _____

Address: _____
Street City State Zip

**I UNDERSTAND THAT YOU WILL PROVIDE THIS
INFORMATION WITHIN 15 BUSINESS DAYS FROM
THE DATE OF REQUEST. THERE IS A \$25 CHARGE FOR THE
FIRST 20 PAGES AND 50 CENTS PER PAGE AFTER THAT.**

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY

Records were picked up today, _____ (Intl)
Records were mailed on _____ by _____ (Intl)
Records were faxed on _____ by _____ (Intl)
Physician approved on: _____ (Date)
Phys. Signature: _____

**IF YOU RECEIVED THIS INFORMATION IN ERROR, PLEASE CONTACT OUR OFFICE
AT (940) 484-7100 AND DESTROY DOCUMENTS.**