DELTA MEDICAL CLINIC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM OTHER ENTITIES

Last Name_____First Name_____MI_____

Date of Birth: _____/_____/_____ Social Security #_____

Telephone number (____) ____-_____

I hereby authorize disclosure of my medical records as follows: (Check all that apply)

- **Entire Chart** - **Doctor's Office Notes** - **Diagnostic Studies (Lab/X-ray)**

- **Records related only to the following date(s) of service_____**

Please release my medical records from:

Name of Provider/Practice _____

Provider's address _____

_____

TO:

Delta Medical Clinic
Kofo Ekadi, M.D.
12001 S. Freeway #210
Burleson, TX 76028

I hereby authorize the release of my medical records as provided above

_____ ___/___/_____
Signature of Patient or Power of Attorney Date