Center for Family Medicine, P.A.
1906 Hwy. 82 West
Sherman, TX 75092
O) 903-892-8398
F) 903-892-6665

Christian Cooper, MD
Helen Schulze, MD
John Kenworthy, DO
Rose Marr, NP
Jeanne Reinert, NP
Lillian Moreno, PA

Ronald Woods, MD
Bradley Hodge, MD
Jasyn Haney, MD
Karen Young, NP
Lacie Mitchell, PA
Deaun Handlang, NP

Authorization to Release Medical Records

(THIS FORM MUST BE FILLED OUT COMPLETELY TO BE VALID.)

Please release requested records **FROM:**_____
Complete Address:_____

Tel.#: _____ Fax#: _____

Description of information to be released:

☐ Lab reports ☐ X-ray reports ☐ EKG's ☐ Office Notes
☐ Immunization records ☐ Complete Medical Records

If not needing Complete Records, provide dates of records being requested:_____
Other (please describe): _____

_____ (initial) I have read and understand that the information authorized for use or disclosure may include records regarding mental health (including Psychotherapy notes) and /or which may indicate the presence of a communicable or non-communicable disease.

Patient's full name:_____ **Date of birth**:_____
Current address:_____ **City:**_____ **State:**____ **Zip Code:**_____
Current telephone #:_____
Please select one: I **(☐ am / ☐ am not)** changing physicians.

Reason for request: _____
_____

Name of person authorizing this disclosure (Please print):_____
Signature:_____ **Relationship to patient**:_____
Tel.#:_____ **Date of Request:**_____

Please release requested records **TO**:_____

Complete Address:_____
Tel.#: _____ **Fax#**: _____

Please check one: ☐ Mail records ☐ Fax records, if possible ☐ Call when records are ready to pick up

_____(initial) I have read and understand that this request shall remain in effect until revoked, in writing, by patient or other authorized individual.
_____(initial) I have read and understand that I should allow at least 15 days business days for completion of this request, but that every effort will be made to complete this request as quickly as possible.

Revised 2-26-2020.