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Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____
Address: _____
Phone #: _____

Please release records **FROM**: _____
Complete Address: _____
Phone #: _____ Fax #: _____
Email: _____

Please release records **TO**: _____
Complete Address: _____
Phone #: _____ Fax #: _____
Email: _____

Description of information to be released:

- | | |
|---|---|
| <input type="checkbox"/> Complete Medical Records | <input type="checkbox"/> EKG's |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Other: _____ | |

If not needing Complete Records, please provide dates of records being requested:

Are you changing physicians? Yes Or No

Reason for request: _____

Name of person authorizing this disclosure (Please print): _____

Relationship to patient: _____ Phone #: _____

*Signature: _____ Date of Request: _____

Please check one: Mail Records Fax Email Pick up paper copy

- * ____ (Initial) I have read and understand that the information authorized for disclosure may include records regarding mental health (including Psychotherapy notes) and/or may indicate the presence of a communicable or non-communicable disease.
- * ____ (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 business days for completion of this request.