CENTENARY FAMILY & URGENT CARE

Medical Record Request Form

By signing this form, I authorize you to release confidential health information about the patient named below, by releasing a copy of my medical records, or a summary or narrative of protected health information, to the person(s) or entity listed below.

Patient Name: _____

D.O.B:_____

Name of entity/person from whom records are requested:

_____
_____
_____

Release the protected health information to the following person(s)/entity:

Centenary Family & Urgent Care
8702 S Lancaster Rd Ste 160
Dallas TX, 75241
Ph: 469-949-8900
Fax: 214-339-2784

The reason or purposes for this release of information are as follows:

_____
_____
_____

Patient signature (or parent, guardian or legal representative):

_____

Date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Texas State Board or Medical Examiners.