Date: _____

To: Tenet Healthcare
Records Management Department
14201 Dallas Parkway
Dallas, Texas 75254
469-893-6111 (Phone) – 469-533-9989 (Fax)
Email: recordsrequests@tenethealth.com

MEDICAL RECORDS RELEASE FORM

I hereby authorize you to release any information including the diagnosis and records of any **treatment or examination** rendered at _____.
(Name of Facility/Hospital)

RELEASE: **Paper Medical Records Only** **X-Rays Only** **Billing**
Emergency Room **Outpatient** **All Records**

Approximate Dates of Service: _____

Additional Information: _____

Please Mail the Above Information to The Following Address:

Doctor's / Requestor's Name_____

Street Address _____ _____

City/State/Zip _____ _____

Phone Number _____ Fax Number_____

*****Contact Name Mandatory*** (if other than above):**

_____

Patient Information: (Type Initials Here If E-Signing This Document _____)

_____ _____ _____
(Patient's Printed Name) (Patient's Date of Birth) (Patient's Phone Number)

_____ _____XXX-XX-_____
(Signature Of Patient or Legal Representative) (Last Four Digits of Social Security Number)

If your name was different at the time of your admission, please include that name and any other aliases as well as your current name. Thank you.

PLEASE NOTE THAT COMPLETION TIME AVERAGES 7-10 *BUSINESS* DAYS.