PRECISION
FAMILY MEDICINE
1428 W. Hebron Parkway, Ste 110
Carrollton, Texas 75010
972-939-4555

MEDICAL RECORDS RELEASE

FAX TO: 972-939-7020

Patient Name		Date of Birth	
Address	City	State	Zip
Phone Number			
Date of Request		**Date Needed**	

AUTHORIZATION

□ I authorize **Precision Family Medicine**
To **RELEASE** information to:

Name of provider or facility

Address
City State Zip
Phone Number

□ I authorize **Precision Family Medicine**
To **OBTAIN** information from:

Name of provider or facility

Address
City State Zip
Phone Number

PURPOSE FOR THIS REQUEST (CHECK ONE BOX ONLY)

□ Healthcare □ Insurance Coverage □ Legal □ Personal □ Other

TYPE OF RECORDS REQUESTED (CHECK ONE BOX ONLY)

□ Progress Notes □Diagnostic Reports □ Operative Repots
□ Entire Copy of My Record □ Other (describe):

AUTORIZATION VALID FOR (CHECK ONE BOX ONLY)

□ This request only □ One year from the date of the authorization

STATEMENT TO RELEASE PROTECTED HEALTH INFROMATION

I understand that:

- My right to healthcare treatment is not conditioned on the authorization.
- I may cancel this authorization at any time by submitting a written request to Precision Family Medicine, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations. The information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records not to exceed $25.00.

Signature of patient or representative Date

Relationship to patient (if requester is not the patient)

FOR INTERNAL USE ONLY

DATE RECEIVED: DATE PRCCESSED: INITIALS: