



724 Pennsylvania Avenue  
Fort Worth, TX 76104  
Phone: (817) 336-1200 Fax: (817) 338-4707

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**\*\*This form must be completely filled out in order to process the request\*\***

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for release: \_\_\_\_\_

Date Requested: \_\_\_\_\_ Date Needed: \_\_\_\_\_

**Released From:**

Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Released To:**

Name/Facility: FORT WORTH MEDICAL SPECIALISTS

Address: 724 PENNSYLVANIA AVE

City/State/Zip: FORT WORTH TEXAS 76104

Phone: 817.336.1200 Fax: 817.338.4707

- Medical Record from (insert date) \_\_\_\_\_ to (insert date) \_\_\_\_\_
- Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

**Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient/Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_