Authorization for the Release of Medical Records

I hereby grant _____ authorization to release all medical records, x-rays, physician notes and information that pertains to my medical care provided by _____ to the following individual, insurance company, legal association and/or medical professional:

Dr. Mitchell Brooks
8333 Douglas Avenue, Suite 350
Dallas, Texas 75225
Phone: 214-987-3888
Fax: 214-987-3889

Patient Name (Print):

_____

Patient Address :

_____

_____

Patient Phone #: _____

Patient Signature:

_____

Witness:

_____

Date:

_____