Request For Release Of Medical Records

Patient's Name: ______________________________ DOB: ______________

Be Released To

Brookwood Family Practice
And Pediatrics
865 Junction Drive
Allen, TX 75013
PH: 214-547-8300 and FAX: 214-547-9787

Name/Organization to whom information is requested from:

____
Name/Organization

____
Address

____
Phone/Fax Number

Information to be released:

_____ Hepatitis B Vaccine
_____ NICU Discharge Summary
_____ Immunization Records
_____ ER Records ___ X-rays ___ Labs
_____ Urgent Care ___ X-rays ___Labs
_____ Information from ________ to _________
_____ Other ___________________________
_____ All Records

____
Authorized Rep. Signature

____
Printed Name of Authorized Rep.

____
Relationship to Patient

____
Date