Dallas Arthritis and Autoimmune disease Center

Authorization to Request Medical Records

Patient's Name _______________________________ Date of Birth _______________

Information Requested

- ☐ All medical records
- ☐ Chart notes
- ☐ Lab results
- ☐ Radiology results (X-rays, MRI, CT scans, etc.,)
- ☐ Procedure notes
- ☐ Pathology report (Biopsy)
- ☐ Other____

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Reason for Request

I request that my or my child's complete records or specific information as listed above be released to:

Dallas Arthritis and Autoimmune Disease Center, PLLC

Phone # 903-508-4230 Fax # 903-553-4388

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Physician or Practice Name

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Address

____

Phone Number and Fax Number

By signing this form, I authorize you to request confidential health information about me or my child. I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to the facility receiving the revocation.

If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be redisclosed.

- ☐ I have read and authorized the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.

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Patient's Signature and Date