Texas Associates of Endocrinology and Diabetes, P.A.

Authorization to Request Medical Records

_____

Patient's Name and Date of Birth

_____

Patient's Signature and Date

_____

Information Requested

_____

Reason for Request

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

Texas Associates of Endocrinology and Diabetes, P.A. (Select location below)

4521 Medical Center Drive STE 400
McKinney, TX 75069
P: 214-547-7557
F: 469-631-7217

600 E. Taylor Street, STE 3011
Sherman, TX 75090
P: 903-357-4579
F: 903-792-8579

_____

Physician or Practice Name

_____

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 effecton 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 nolonger be protected by federal privacy regulations or may be redisclosed.

I have read and authorize the disclosure of the protected health information as stated. I may receive a copyof this form after I have signed it.