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**Authorization To Release Medical Records**  
**(This Form Must Be Filled Out Completely To Be Valid.)**

Please release requested records **FROM:** \_\_\_\_\_

Complete address: \_\_\_\_\_

Tel. # \_\_\_\_\_ Fax# \_\_\_\_\_

Description of information to be released:

\_\_\_\_\_ Lab reports \_\_\_\_\_ X-ray reports \_\_\_\_\_ EKG's \_\_\_\_\_ Office notes

\_\_\_\_\_ Immunization records \_\_\_\_\_ Complete medical records

\_\_\_\_\_ Other (please describe): \_\_\_\_\_

\_\_\_\_\_ (initial) I understand that the information authorized for use or disclosure may include information regarding mental health and / or which may indicate the presence of a communicable or non-communicable disease.

Patient's full name: \_\_\_\_\_

SS#: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Current address: \_\_\_\_\_

Current telephone # \_\_\_\_\_

I ( am / am not ) changing physicians. (PLEASE CIRCLE ONE.)

Reason for request: \_\_\_\_\_

Name of person authorizing this disclosure (Please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Tel. # \_\_\_\_\_ Date of request: \_\_\_\_\_

Please release requested records **TO:** \_\_\_\_\_

Complete address: \_\_\_\_\_

Tel. # \_\_\_\_\_ Fax #: \_\_\_\_\_

**PLEASE CHECK ONE:** \_\_\_\_\_ Mail records \_\_\_\_\_ Fax Records (20 pages or less)

\_\_\_\_\_ Call when records are ready to pick up.

\_\_\_\_\_ (intial) This request shall remain in effect until revoked, in writing, by patient or other authorized individual. Please allow at least 15 business days for completion of this request, however, we will make every effort to complete your request as soon as possible.