

Medical Records Release

Patient: _____

Date of Birth: ____ - ____ - ____ Social Security # ____ - ____ - ____

Authorization for Medical Records

The above patient recently asked for her records to be transferred.

I hereby request and authorize:

(Name of previous doctor or facility)

Phone # (____) ____ - ____ Fax # (____) ____ - ____

Address: _____

To send all necessary records to:

Dr. Ralph Joseph
1105 Central Expwy. N.
Suite 330
Allen, TX 75013
(972) 747-6370
Fax (972) 747-6371

Patient or responsible party: _____

Date: ____ - ____ - ____

