AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Previous Name: _____ Phone Number: _____ SSN: _____

I hereby authorize that my medical records be released to:

Christy Walker, M.D.
6300 West Parker Road Building 2, Suite 325
Plano, TX 75093
Phone: 972-981-3535
Fax: 972-981-3536

This information is to be released from:

Physician/Medical Facility: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Fax Number: _____

This request applies to:

☐ All health care information ☐ Progress Notes ☐ Recent pap smear/labs ☐ Labs

☐ History / Physical: ☐ Mammograms ☐ Radiology Reports ☐ Operative Notes

☐ Other: _____ ☐ Reason for request: _____

I understand that the information to be disclosed may include history of DRUG or ALCOHOL ABUSE, OR MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), and laboratory test results, treatment progress or any other such related information.

I further authorize that a photocopy of this authorization is acceptable as an original.

I UNDERSTAND THAT THESE RECORDS ARE CONFIDENTIAL AND CANNOT BE DISCLOSED WITHOUT WRITTEN AUTHORIZATION, EXCEPT OTHERWISE AS PROVIDED BY LAW. MY CONSENT MAY BE REVOKED AT ANY TIME. THIS AUTHORIZATION SHALL EXPIRE SIXTY (60) DAYS FROM THE DATE OF MY SIGNAUTRE.

Signature of Patient or Legal Representative: _____ Today's Date: _____

Signature of Witness: _____ Today's Date: _____