

MEDICAL RECORDS REQUEST FORM
RECORDS TO BE RELEASED TO MY PRIMARY CARE
PHYSICIAN

6700 Buenos Aries
North Richland Hills, Texas 76148
(817) 281-3121 FAX (817) 281-7649

Consent to release Medical Records To:
MARK K. HAMMONDS, M.D.

I, _____, D.O.B. ___ / ___ / ___, S.S.# _____ - _____ - _____

hereby give my written consent for any outside hospital, emergency room, or medical clinic to forward any medical records from my visits there to my primary care physician, Mark K. Hammonds, M.D., or Manish Desai M.D., at their fax # (817) 281-7649. This consent is hereby given indefinitely until specifically revoked by me. This consent is for all records including those of personal nature. Larger records of non-urgent nature may be mailed to the above address.

Thank you for your cooperation.

PATIENTS SIGNATURE

DATE