MEDICAL RECORDS RELEASE

_____ _____

(NAME OF PATIENT) (DATE OF BIRTH)

_____

(STREET ADDRESS) (CITY/ STATE) (ZIP)

AUTHORIZES:

_____

(NAME OF PHYSICIAN/MEDICAL FACILITY)

_____

(STREET ADDRESS) (CITY/STATE) (ZIP)

_____

(PHONE NUMBER) (FAX NUMBER)

RELEASE RECORDS TO:

SUREKHA MACHUPALLI M.D.
2865 MCDERMOTT RD 225
PLANO, TEXAS 75025
PHONE: 972 - 908 - 2444
FAX: 972 - 908 - 2418

INFORMATION TO BE RELEASED:

- ☐ ALL CLINIC RECORDS
- ☐ IMMUNIZATION RECORDS
- ☐ ELECTROCARDIOGRAMS
- ☐ OTHER
- ☐ VISUAL FIELDS
- ☐ X-RAY REPORTS
- ☐ ALLERGY RECORDS
- ☐ EYE RECORDS
- ☐ OFFICE NOTES
- ☐ LAB REPORTS

PURPOSE OR NEED FOR DISCLOSURE:

- ☐ FURTHER MEDICAL CARE
- ☐ DISABILITY DETERMINATION
- ☐ PAYMENT OF INSURANCE CLAIM

I authorize the release of my medical records in accordance with the specifications listed above. I understand written notice is needed to cancel this request.

_____

(Signature) (Date)

PATIENT IS: ☐ MINOR
☐ DISABLED ☐ LEGAL GUARDIAN
☐ NEXT OF KIN OF DECEASED

_____

(Authorized signature)