The Carrell Clinic
9301 N. Central Expressway, Suite 500
Dallas, TX 75231
Phone: 214-220-2468
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Medical Records Release Form

Authorization for release or request of Protected Health Information:

Patient Name _____Date of Birth _____/_____/_____

Email Address_____

I authorize The Carrell Clinic to release, disclose, or request confidential health information about me, by releasing or requesting a copy of my medical records, a summary or narrative of my protected health information, or verbally to the individual or organization listed below.

I am requesting that my medical records be ☐ released to or ☐ obtain from:

Name: _____

Address: _____City_____State_____Zip_____

Office Number: _____Fax: _____

Please release the following information:

☐ Entire Medical Record **No X-rays**

☐ From:_____To:_____

☐ Last 3 visit notes

☐ Copies of most recent X-rays **(72 hr. notice)**

☐ Last Labs, Path Reports or diagnostic reports

☐ Other_____

_____ _____
Signature or Individual's Legal Representative Date

_____ _____
Printed Name or Legal Mark Relationship to the Patient