Medical Records Request for the following (Patient Information)

Name: _____ DOB: ____/____/____
Address: _____
City: _____ State: _____ Zip: _____
Phone No.: _____
I hereby authorize _____ to release to: ***Four Points Wellness, PLLC***

☐ By mail: 107 SW 7th Avenue, Mineral Wells, TX 76067
☐ By fax: (817) 646-7433
☐ By e-mail: kayme@fourpointswellness.org

I hereby authorize the release of the following information, including, if applicable, any treatment or test results for mental health, alcohol and/or drug abuse, or reportable communicable diseased including acquired immune deficiency syndrome or human-immunodeficiency virus infection.

☐ Entire medical records
☐ Partial from _____ to _____
☐ Description of records (diagnosis, type of record, etc).____

- o Lab results
- o Radiology reports
- o Consult notes
- o History and Physical
- o Discharge Summary
- o Immunization reports
- o Medication List

☐ Other (please specify) _____ Expiration:
☐ This is a one-time request
☐ This request is ongoing until withdrawn

Patient Signature: _____ **Date:** _____ or
Signature of legal representative: _____
Name of legal representative: _____
Relationship to patient: _____