Request for Release of Medical Records

Date Received: ____________

Requesting Medical Records from:

Physician: ____

Street Address: ____

City: ____ State: _________ Zip: ________________

Email: ____ FAX: _________________________________

Please Release the Medical Records of:

Patient First Name: ____________________________ M.I. _____ Last: _____________________________

Date of Birth: _____________ What records are being requested? (particular dates, illness, all records, etc.):

____

Reason for request: ☐ Moving ☐ Change of insurance ☐ Other (specify) _____________________

Send the Requested Medical Records to:

John R. Porter, MD, PA
1112 N. Floyd Rd, Ste. 10
Richardson, TX 75080
Fax: 972-235-3285
Email: jrporter@gmail.com

I understand that I may revoke this authorization/request at any time. My revocation must be in writing and provided to John R. Porter, MD, PA. I understand that the revocation will not affect the actions of the original authorization of release prior to the request to revoke.

Authorized Signature: ____

Date: ______________________________ Relationship to Patient: _______________________________