

Medical Records Release Form

Medical Record Release Requested From:

Doctor's Office: _____

Address: _____

Phone Number: _____

Fax Number: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

**Bridlewood Family Healthcare
3400 Long Prairie Road Suite 200
Flower Mound, TX 75022
Dr. Brian D. Glaser
Dr. Courtney A. Haught
972-899-6300
972-899-6020 (Fax)**

Limitations on the information you may release subject to this Release Form are as follows: _____

The reason or purposes for this release of information are as follows: _____

Patient Name: _____ **DOB:** _____

Signature of Patient (Parent, Guardian, or Legal Representative): _____ **Date:** _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

I DO NOT WISH TO HAVE MY RECORDS RELEASED