Authorization for the Release of Medical Records

Patient Name (please print): _____

Date of Birth: _____ Daytime Phone: (____)_____

Information to be released **FROM:**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____)_____ Fax: (____)_____

Reason for request: _____

Information to be released **TO:**

W Brad Gates, MD, PA

3108 Midway Rd, Suite 105

Plano, TX 75093

Phone: (972)801-9100 Fax: (855)753-3285

Please release the following (check all appropriate)

All records _____

Progress notes _____

Lab results _____

Immunizations _____

Other: _____

Including information about:

HIV/AIDS _____

Drug/alcohol use _____

Mental Health _____

I understand that I may revoke this consent in writing at any time except to the extent action has already been taken. The information released is for the specific purpose stated above. I understand I will be responsible for any charges occurred based on this request.

Patient signature (Guardian for patients under 18 years of age Date