ANDERSON MEDICAL GROUP
OF TEXAS
YOUR HEALTH. OUR CARE.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Previous Name: _____

Date of Birth: _____ Social Security #: _____

I request and authorize:

Anderson Medical Group of Texas
1411 N. Beckley Ave. |Pavilion III, Suite 352
Dallas, Texas 75203
(469) 981-2648 (O) | (214) 943-8213 (F)

to release healthcare information of the patient named above to:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates,

_____

_____

☐ All healthcare information
☐ Other:

_____

_____

Patient's Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.
Thank you for your prompt attention.