ANDERSON MEDICAL GROUP
OF TEXAS
YOUR **HEALTH.** OUR **CARE.**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____

Date of Birth: ____________________

I request and authorize ____

to release healthcare information of the patient named above to:

☐ Anderson Medical Group of Texas
1411 N. Beckley Ave.
Pavilion III, Suite 352
Dallas, Texas 75203
Phone: (469) 981-2648
Fax: (469) 981-2649

This request is for:

☐ Howard E. Anderson Jr., M.D.

This request and authorization applies to:

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

☐ All healthcare information
☐ Other:
____
____

Please send all requested information to the address or fax number listed above.

Patient's Signature: ______________________________ Date Signed: __________

Thank you for entrusting us with your health care.

Patient Contact Information:

Cell Phone	Home Phone	Email

Pharmacy Information:

Pharmacy Name	Pharmacy Phone Number	Location (City)

Specialty Physicians (Please list all other physicians you are currently seeing):

Physician	Specialty	Phone Number

Thank you for entrusting us with your health care.