Flower Mound Family Health Center
2261 Olympia Drive Suite 100
Flower Mound, Texas 75028
Tel: (972) 691-8585
Fax: (972) 691-8686

Medical Release of Information

Patient Name: _____

Date of Birth: _____ Social Security Number _____

I hereby authorize _____
To release medical information on the above names patient to:

_____

_____

_____

Signature: _____ Date: _____

Include:

1. All Medical Records
2. Lab/X-rays/MRI Reports
3. Immunization Records
4. Other _____

Fees: Copies of Medical Records are subject to a $25.00 pre payment before records are copied.