Medical Records Release Authorization

Patient's Name:____
Address:____
Phone:__________________ DOB:_____________________ SSN:__XXX-XX-____________
Which records are needed:____
Reason for transfer/request:____

I, the undersigned, do hereby authorize and direct you to

( ) Furnish records **TO** DFW Sports Medicine from:

( ) Release records **FROM** DFW Sports Medicine to:

******IMPORTANT NOTICE: Per DFW Sports Medicine Healthcare Practice Policy, we only copy, print, mail or fax DFW Sports Medicine records. We do not copy, print, mail or fax other Doctor's medical records. Please contact your past doctor for these records.**

Write the Practice Name or Hospital Name/Physician name:

Name:____
Address:____
Phone:____
Fax:____

Check how records are to be received: Mail_______ Pick-Up_______ Fax___X______

(If **all** records are requested, **DFW Sports Medicine will mail records**)

DFW Sports Medicine PLLC
4833 Medical Center Dr 6E, McKinney, TX 75069
Or
1850 Lakepointe Dr, Ste 700, Lewisville, TX 75057
Phone 469-430-9380
Fax 469-242-9539

I understand that my request will be processed within the timeframes set forth by state law or within 30 days, whichever is less. I understand that I am responsible for cost for copies.

A copy of this authorization is as valid as an original and will expire 6 months from the date below.

Rathna R. Nuti, MD
Board Certified in Family Medicine & Sports Medicine
www.dfwsportsmed.com
Phone: (469) 430-9380 Fax: (469) 242-9539

Medical Records Request Fees:

- **Print**- I understand that you may charge me a fee of up to $25 if I request my entire chart for personal use
- **Oversized Document**- I understand that you may charge me a fee of up to $30 if I request my entire chart for personal use and it exceeds 100 pages
- **NO CHARGE**- Any records that are to be released for the purpose of continuation of care to a designated physician or insurance company.

I UNDERSTAND THAT DFW SPORTS MEDICINE DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS OR FACILITIES.

____

Patient/ Guardian/ Representative Printed Name

____

Relationship to patient (if signed by other than patient) **Witness (optional)**

____

Patient/ Guardian/ Representative Signature **Date**

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