DFW Sports Medicine

# 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 469-645-0200**
**Fax 469-320-9550**

**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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