

Plano Medical Center  
2105 W. Spring Creek Pkwy, Suite A300  
Plano, TX 75023  
Phone: (972)208-2900  
Fax: (972)491-6750

Request for Release of Medical Records

I, \_\_\_\_\_ (D.O.B. \_\_\_\_\_ )  
here by authorize the release of my medical records and information from:

Plano Medical Center

To the following individual or facility:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

I understand that my private medical information will be released in full to this facility, unless other wise specified, and that I may be responsible for any charges incurred for the reproduction of my medical records.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_