Kelly Jackson, FNP-C
9423 S US Highway 69
Huntington, Texas 75949
FAX (936)955-5541

MEDICAL RECORD REQUEST FORM

Patient Information
Full Name: _____
Date of Birth: _____
Phone Number: _____
Address: _____
City/State/ZIP: _____

Records Requested From (Provider/Facility Name):

Address: _____
Phone: _____ Fax: _____

Records To Be Sent To:
Texas Tone Dermatology
Fax: (936)955-5541

Email (if applicable): _____

Information to be Released (Check all that apply):
☐ Complete Medical Record
☐ Office Visit Notes
☐ Lab Results
☐ Imaging Reports
☐ Other (please specify): _____

Date(s) of Service Requested:
From: _____ To: _____

Purpose of Request:
☐ Continuity of Care
☐ Personal Use
☐ Insurance
Delivery Method:
☐ Fax
☐ Mail
☐ Patient Pickup

Authorization & Consent
I hereby authorize the release of my protected health information as described above. I understand that this authorization is voluntary and may be revoked at any time in writing, except to the extent that action has already been taken in reliance on it. I understand that information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

Patient Signature: _____
If Signed by Legal Representative:
Name: _____
Relationship to Patient:_____Signature_____

Date: _____