

# Medical Records Release

To: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

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

**\*Please forward a copy of my medical records to:**

***John H. Alexander M.D., F.A.C.S***

*11970 North Central Expressway, Suite 600*

*Dallas, TX 75243*

*(972) 247-7767*

*(972) 247- 6268 Fax*

\_\_\_\_\_

\_\_\_\_\_

XXX-XX-\_\_\_\_\_  
Patient's Name (Print)

DOB

SS#

\_\_\_\_\_  
Signed

Comments:

\_\_\_\_\_

\_\_\_\_\_

