MEDICAL RECORDS REQUEST

Dear Dr. ____________________________:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

__________ Complete record

__________ Records of care from _____________________ to ________________ only

__________ Records of care concerning the following condition(s) :

____

__________ Other. Specify: ____

__________ Confer with other person orally about information in my medical record

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

Initial ______ Date ____________________

to the following person(s):

Amarillo Medical Specialists, LLP **Via Fax (Preferred): (806) 356-0045**
Drs Do, Keister, Miranda, Norris

or Via Mail: Amarillo Medical Specialists, LLP
Drs Do, Keister, Miranda, Norris
1215 S. Coulter St., Ste 301
Amarillo, TX 79106
The reasons or purposes for this release of information are:

____
____

I understand that you will provide this information within 15 business days from receipt of request.

Signed:____ Date: ____________
(Patient or person legally authorized to consent on patient's behalf)