Denton Internal Medicine Associates
2900 N I-35, Suite 118
Denton, TX 76201

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient Name: _____ **Date of Birth**: _____

Release my protected health information FROM the following person(s)/entity:

Name:_____

Street: _____

City: _____ State: _____ Zip: _____

Release my protected health information TO the following person(s)/entity:

Denton Internal Medicine Associates
2900 NORTH I-35, SUITE 118
Denton, Texas 76201

Phone: (940) 380-8100
Fax: (940) 380-8112

☐ **Aitazaz A. Shah, M.D.**

☐ **Farah Shah, M.D.**

_____ _____
Patient signature ***Date***
(or parent, guardian, or legal representative)

I understand that you will provide this information within 15 days from receipt of request, and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

*** Please do not fax if over 25 pages.**