MEDICAL RECORDS REQUEST

Dear Dr.	:	:	
indicated	er will authorize you to provide a co by the check mark(s) below) or to a 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 medi	cal record
infection,	OS. I consent to the release of any post, antibodies to AIDS, or infection wedical records.	_	
Initial	Date	_	
to the fol	lowing person(s):		
	Medical Specialists, LLP Via Keister, Miranda, Norris	a Fax (Preferred): (80	06) 356-0045
Drs Do, I 1215 S. (Amarillo	Iail: Amarillo Medical Specialists, L Keister, Miranda, Norris Coulter St., Ste 301 , TX 79106		
	ons or purposes for this release of in	normation are.	
I understarequest.	and that you will provide this inform	nation within 15 business days	from receipt of
Signed:_	1 11 21 12		ate:
(Patient	or person legally authorized to cons	ent on patient's behalf)	