Medical Records Release Form

By signing this form, I authorize Crown Imaging to release the patient's named below confidential health information, by releasing a copy of the medical records, or a summary or narrative of the protected health information to the person(s) or entity listed below.

Patient Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____

Date of Birth _____

Name of entity from whom records are requested:

Crown Imaging
7515 Greenville Ave Suite 200
Dallas, TX 75231
PH: 972-759-5140/FAX: 972-759-5150

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

_____

_____

_____

_____ _____

Patient signature (or parent, guardian or legal representative) **Relationship to patient**

_____

Date

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