

AUTHORIZATION TO RELEASE RECORDS

North Texas Hand Surgery Associates, Ltd., L.L.P.
8230 WALNUT HILL LANE #212
DALLAS, TEXAS 75231
214-368-3776

Patient Name: _____

Date: _____

I **DO** authorize the release of my medical records to be sent to my primary care physician and/or the physician that referred me to North Texas Hand Surgery Associates.

Patient/Guardian Signature

I **DO NOT** authorize the release of my medical records to be sent to my primary care physician and/or the physician that referred me to Dr. Stripling or Dr. Morrison.

Patient/Guardian Signature

Witnessed by: _____