Release of Medical Records

To Whom It May Concern:

This authorization permits ____

____

to send my protected health information (medical records) to

James A Haley M.D.
2817 South Mayhill Road Suite 120
Denton Texas 76208
(940) 565-9969 (fax)

I understand that I retain the right to revoke this authorization in writing. As well, this authorization shall expire six months from the date noted below.

Name: ____

Date of Birth: ___________________________________

Social Security Number: __________________________

Thank you in advance for your prompt attention to this matter.

Sincerely,

_________________________________ _________________________

Signature Date

Records to include dictated documentation, Progress Notes, Laboratory Findings, Imaging Reports, Pathology Findings and Medication List.

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