JOHNSON MEDICAL ASSOCIATES
Comprehensive Medicine | Traditional | Holistic | Alternative

MEDICAL RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE:

JOHNSON MEDICAL ASSOCIATES, P.A.
ATTN: Alfred R. Johnson, D.O.
997 Hampshire Lane
Richardson. TX 75080-8105

TO RELEASE MEDICAL INFORMATION CONCERNING MYSELF TO:

_____
Employer, Insurance, Worker's Compensation, Physician, Hospital, Or Other

_____
Address Line 1

_____
Address Line 2

_____
City State Zip Code

_____
Fax No. Telephone No.

☐ LETTER ☐ COPIES (explain below)

PURPOSE/NATURE OF REQUEST:

_____

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_____ _____ ____/_____/_____
Patient's Signature Authorizing Release Printed Name Date of Birth

_____/_____/_____
Social Security Number (for identification purposes)

Date:

_____/_____/_____

_____ _____
Witness Signature Witness Printed Name