PRESTON SURGERY CENTER
7589 Preston Road Ste 100
Frisco, Texas 75034
Phone: 214-387-4100
Fax: 214-387-4103

Medical Information Release Form

(HIPAA Release Form)

Patients Name: _____ Date of Birth: _____/_____/_____

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____
Child(ren)_____
Other_____

☐ Information is **NOT** to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES:

Please Call: ☐ My home ☐ My Work ☐ My Cell Number: _____

If unable to reach me:

☐ You may leave a detailed message
☐ Please leave a message asking me to return your call
☐ _____

Signature: _____ Date: _____

PSC0148 REVISED 10/18/17