

Release of Medical Records

I, _____ hereby request that you release my medical records including _____ labs _____ X-rays to:

LeeRoy McCurley M.D., P.A.
775 W. Westchester Parkway, Suite 102
Grand Prairie, TX 75052
Phone: 972-266-5354 Fax: 972-266-7876

Signature of Patient or Personal Representative

Date

Patient's Date of Birth

Social Security Number

Address

City

State

Zip Code

Witness

Date

Name of Previous Office or Physician(s)

Phone#/Fax#

Address

City

State

Zip Code