



REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ D.O.B. _____

I hereby request medical records be released:

To / From

(please circle one)

Jeffrey Adelglass, M.D., F.A.C.S.

6020 W. Parker Road, Suite 400
Plano, TX 75093
972-492-6990 (ph)
972-394-4405 (fax)

To / From

(please circle one)

Physician's Name

Address

Phone

Fax

Reason: _____

Patient's Signature (or patient's parent or legal guardian)

Date