Request for Medical Records

Date:____________________

Patient Name:___________________________________

Date of Birth:_____________

I hereby request that my medical records be released from:

Doctor or facility name:_________________________________

Address:_________________________________

Phone:_________________________________

Fax:_________________________________

Please Forward These Records To:

Thomas K. Alexander, M.D.
Trung N. Dao, M.D.
399 W. Campbell Rd. #212
Richardson, Texas 75080
Phone: 972-234-4994
Fax: 972-234-4412

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Patient Signature

Photocopied signatures are valid as originals