ACRC TRIALS

MEDICAL RECORDS RELEASE

PATIENTS: Please complete and fax to (972) 692-7713. Also, indicate the Coordinator's name on the fax.

To: _____ Date: _____

_____
Physician or Hospital Name

Street or P.O. Box _____
City, State, Zip _____
Phone Number _____
Fax Number _____

I hereby authorize and request that you release my complete medical record and the following specific reports (if available):

- ✓ Chest or Sinus Series X-Rays
- ✓ Medical Records from _____ to Present
- ✓ Lab Results

Other:

Patient Information

First Name: _____ Last Name: _____
SS#: _____ DOB: _____
Address (Street, City, State, Zip): _____
Patient Signature: _____
Date: _____

Please send this information to:

ATTN: Clinical Research Coordinator _____
5655 W. Spring Creek Pkwy, Suite 125, Plano, TX 75024
☎ (972) 354-1520 ☎
Fax #: (972) 692-7713

Please fax the completed form to (972)692-7713.