Glena Davis, D.O.
108 SW 6th Ave.
Mineral Wells, TX 76067
940-328-1200/fax 940-328-1205

Medical Records Release

Patient Information

Full Name _____

Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Home Telephone Number _____(leave blank if none)

Cell Telephone Number _____(leave blank if none)

Email _____

Is the Patient a minor or dependent adult? Yes _____ No _____

I hereby authorize and request a release of my complete medical records in your possession concerning my illness and/or treatment from the below named Doctor's office to Glena Davis, D.O. This authorization will remain valid until I revoke it by written notice.

Doctor's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Fax Number _____

Phone Number _____

Signature _____

Relation to Patient _____

Date _____