FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

6131 Luther Lane, Suite 216
Dallas, Texas 75225
Phone: 214-987-2020
Fax: 214-739-3725

Authorization for Fagadau, Hawk, & Swanson M.D. to RELEASE the medical information of:

Patient Name: _____ D.O.B _____ Phone:_____

Patients Address: _____

_____

I authorize Fagadau, Hawk, & Swanson, M.D. to send my health records to:

Doctor/Company _____

Phone # _____ Fax: _____

Address _____

_____

City, State _____

☐ **Complete Record**

☐ **Records of care from the following dates: _____ to _____**

☐ **Records concerning the following conditions: _____**

_____

☐ **Other (please specify): _____**

The reason or purpose for the release of this medical information is:

_____

_____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial _____ Date: _____

The charge for copying records is $25.00 or $_____ and has to be paid prior to the release of any records. Fees for preparing and furnishing this information will be charged according to rulings set forth by the Texas State board of Medical Examiners. Please allow a minimum of three (3) to fifteen (15) business days for the records to be copied for pick up or mailing.

Patient Signature: _____ Date: _____