PARK CITIES PERSONAL PHYSICIANS
REQUEST FOR MEDICAL INFORMATION AND/OR RECORDS

By signing below, I authorize (M.D. or Medical Facility)_____
At (address)_____
(Fax #)_____To release any and all of my medical records. These records are to be sent to Dr. Sarah Davis M.D. at the Park Cities Personal Physicians, 6901 Snider Plaza, Suite 130, Dallas, Texas 75205, Phone # 214-361-7855, Fax # 214-361-2552. I ask that the information be released for the following purpose: _____

Signature: _____Date_____

Printed Name: _____

Date of Service: _____

Social Security #_____Date of Birth: _____

Address: _____

Telephone: _____

Witness Signature: _____Date: _____