ACRC TRIALS

MEDICAL RECORDS RELEASE

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

Date: _______________

To:

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) to ACRC TRIALS.

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

☐ Other: ____

Patient Information:

First Name: ________________________ Last Name: ___________________________
SS#: ________________________________ DOB: _________________________________

Address: ____

Please send this information to:

ACRC TRIALS

ATTN: Clinical Research Coordinator ________________________________

5425 W. Spring Creek Parkway, Suite 130, Plano, TX 75024
☎ (972) 354-1520 ☎
Fax #: (972) 692-7713

Patient Signature: ___________________________________ Date: _____________________

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