LEO W. MACK JR., MD, PA

5777 New Copeland Rd.
Suite 200
Tyler, TX 75703
903.630.7007
903.592.8141
www.eyehelp.com

REQUEST FOR MEDICAL RECORDS

Date: ____

Patient Name: ____

Patient DOB: ____

TO: ____

____

Upon receipt of this written request, please forward a copy of my medical records, including but not limited to daily office visits, testing results, surgical data, and hospital admissions for the purpose of continued medical care.

Please mail or fax to the office of Leo W. Mack, Jr., M.D., P.A. at the address / fax number listed above.

____

Printed name of patient (or authorized person and relationship)

____

Signature of patient (or authorized person) Date

____

Witness Signature Date

Note: Pursuant to Texas Administrative Code Title 22, Part 9, Chapter 165, Rule §165.2, a physician shall furnish copies of medical and/or billing records requested…as provided by the Medical Practice Act, §159.005. Physicians must permit the patient or an authorized representative access to inspect medical and/or billing records and may not provide summaries in lieu of actual copies unless the patient authorizes the summary… Medical records shall include copies of medical records of other health care practitioners contained in the records of the physicians to whom a request for release of records has been made.

01/2017