**North Texas Pediatric Urology Associates**
Dr. David Ewalt ☙ Dr. William Strand

# Request and Authorization for the Release of Medical Records
## to Urology Clinics of North Texas

To: _____ Date: _____
_____
_____ Fax: _____

This authorizes you to provide a copy, summary, or narrative copy of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information to ***Urology Clinics of North Texas***. I understand that this information may include, but is not limited to physical/emotional illnesses, past medical history, diagnosis, complications and recommendations, prognosis and evaluation and treatment records of alcohol or drug abuse.

□ Complete medical record
□ Records of care from the following dates: _____ to _____.
□ Specific reports:
_____ Pathology _____ Operative report _____ Discharge Summary _____ X-ray Report dated: _____
□ Other: _____

**Patient Name:** _____

**Patient Date of Birth:** _____

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: _____

Release to the following person(s) at
North Texas Pediatric Urology Associates
214-750-0808

**Dr. David Ewalt**

□ **Mail:** 8315 Walnut Hill Lane,
Suite 205
Dallas, TX 75231

□ **Fax:** **214-750-6341**

**Dr. William Strand**

□ **Mail:** 4001 W. 15th Street
Suite 300
Plano, Tx 75093

□ **Fax:** **972-943-9932**

These records are needed for patient care.

Patient Signature: _____ Date: _____

Personal Representative: _____ Date: _____