MEDICAL RECORDS RELEASE

To: _____

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Telephone: _____

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Please forward a copy of my medical records to:

John H. Alexander, M.D., F.A.C.S.
8 Medical Parkway, Suite 310, Dallas, TX 75234
Ph: 972-247-7767 Fax: 972-247-6268

_____	_____	XXX-XX-_____
Patient Name (print)	**DOB**	**Last four digits of SSN**
_____	_____	
Patient Signature	**Date**	

Comments:

_____

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