Thomas J. Parr, M.D., F.A.C.S.

Orthopedic Surgery and Sports Medicine

PLEASE SEND MEDICAL RECORDS TO DR. PARR

Patient's Full Name _____Date of Birth: _____

I hereby authorize: _____
(physician or medical treating facility)

_____
(office address)

_____
(city, state, zip)

To send my medical information, as indicate below, to:

Thomas J. Parr, MD, PA
14090 Southwest Fwy, #130
Sugar Land, TX 77478

Records from _____ to _____
(beginning date) *(ending date)*

(please initial if applicable)

_____Copies of Records of Clinic Visits
_____Copies of Records of Surgical Procedures and other Hospital or Outpatient Notes
_____Copies Outside Reports Provided By Other Providers (ie: Lab Test Reports, Imaging Reports, or Reports from Referring or Consulting Physicians)
_____Copies of X-rays
_____Other:_____

1.) I understand that my records are confidential and cannot be disclosed without my authorization, except as otherwise provided by law.
2.) I understand that a photocopy or facsimile of this authorization is as valid as the original.
3.) I understand that I may revoke this authorization at any time. In the absence of my prior revocation, this authorization will automatically expire in one year from the date of signature.

_____ _____
(Patient's Signature) *(Parent's/Legal Guardian's Signature)*

_____ _____
(Date) *(Witness to Parent's/Legal Guardian's Signature)*