Texas Elite HEALTH CLINIC

1304 Village Creek Drive, Suite 300
Plano, TX 75093
P: 972.402.9700 F: 972.402.9706

AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization is effective from the date on which it was signed and expires in 90 days. I understand that I may revoke the authorization at any time, except to the extent that action has already been taken in reliance upon to Texas Elite Health Clinic, LLC.

Patient Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

I authorize my records be released from:

Texas Elite Health Clinic, LLC

1304 Village Creek Dr.

Suite 300-B

Plano, TX 75093

Phone: 972-402-9700 Fax: 972-402-9706

I authorize my records be released to:

Doctor/Facility/Insurance:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Fax:_____

Patient Signature:_____ Date:_____