

Medical Records Release Authorization

Name of institution medical information is to be obtained from:

I hereby request that my medical records be released to:

↑ **James D. Mackey, MD**

↑ **Kiran Kancharla, MD**

Southlake Oncology
1545 E. Southlake Blvd. Suite 280
Southlake, TX 76092
817-416-0202 Phone
817-749-0369 Fax

Las Colinas Cancer Center
7415 Las Colinas Blvd. Suite 100
Irving, TX 75063
214-379-2700 Phone
214-379-2750 Fax

Please send copies of the following:

- *Consultation Reports*
- *History and Physical*
- *Current Lab Reports*
- *Operative Reports*
- *Chemotherapy Records*
- *Procedure Notes*
- *X-Ray films and/or CT Scans*
- *X-Ray and/or CT Scan Reports*
- *Pathology Reports*
- *Other: _____*

Printed Patient Name

Date of Birth

Signature of Patient or Legal Representative

Date Signed