Reese A. Mathieu, M.D,
3601 North Star
Richardson, Texas 75082
Ph: 972-235-0385 / Fax: 972-235-3859

Date:_____

Dear Dr._____

Dr. Phone # _____ Dr. Fax #_____

This letter will authorize you to provide a copy of the medical records as indicated by the check mark below or to otherwise release confidential information. At this time I am requesting the following:

_____Complete record
_____Records of care from _____ to _____only

Please release records for (child's name and date of birth).

_____

_____

Signature: _____

Date_____

The Reasons or purposes for this release of information are:

_____

_____