

Harmony Family Health

Daniel J. Chartrand, MD

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406 West Main Street
Allen, Texas 75013

Request for release of medical records:

Patient's Name:

Date of Birth:

Physician's Name:

Street Address:

City:

State:

Zip:

Telephone:

Fax:

This is to authorize your office to release to Dr. Daniel J. Chartrand a copy of the medical records of the above named patient.

Requested By:

Patient / Guardian Signature:

Date:
