

Form: Request for health care records

**PREVIEW**  
RECORDS AUTHORIZATION: HEALTH CARE

TO WHOM IT MAY CONCERN:

I, [Petitioner Name], provide this notice authorizing the release of all documents and tangible records of the following health care professionals or entities which relate to my past, present or future physical, mental or medical condition:

Those authorized to make this release include medical doctors, physicians, psychiatrists and their offices, clinics or hospitals and further includes dentists, psychologists, social works, medical technicians and any other provider of health care.

**PLEASE DO NOT COPY**

The authorization is for release limited to [Petitioner Attorney], who is my attorney and the representatives of my attorney, including the bearer of this document, and includes records, billing statements, notes, photographs, x-rays, opinions and reports.

\_\_\_\_\_  
[Petitioner Name]  
Social Security: [Social Security Number]  
[Address]

State of Texas  
County of \_\_\_\_\_

**THIS DOCUMENT**

Subscribed and sworn to before me by \_\_\_\_\_ on \_\_\_\_\_.

\_\_\_\_\_  
Notary Public, State of Texas

\_\_\_\_\_  
Notary's typed or printed name  
My commission expires: \_\_\_\_\_

**THANK YOU** [or Notary's Stamp]

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