

BAYLOR MARTHA FOSTER LUNG CARE CENTER  
4004 WORTH ST. SUITE 300 DALLAS, TX 75246 214 820 3500

**MEDICAL RECORDS RELEASE AUTHORIZATION**

I hereby authorize and request that you release my complete medical record and the following specific reports (if available).

Pulmonary Functions \_\_\_\_\_  
Arterial Blood Gases \_\_\_\_\_  
Chest & Sinus Series x-rays \_\_\_\_\_

Other \_\_\_\_\_  
\_\_\_\_\_

TO: \_\_\_\_\_  
(Dr. or Hospital)  
\_\_\_\_\_  
(Street, P. O. Box)  
\_\_\_\_\_  
(City, State, Zip)

FROM: Baylor University Medical Center, Dallas  
Baylor Martha Foster Lung Care Center  
4004 Worth Street, Suite 300  
Dallas, Texas 75246  
(214) 820-3500 (PH)  
(214) 820-9799 (FAX)

By: \_\_\_\_\_  
(Patient Name)  
\_\_\_\_\_  
(Street, P. O. Box)  
\_\_\_\_\_  
(City, State, Zip)  
\_\_\_\_\_  
(Date of Birth)

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Legend:

**BAYLOR UNIVERSITY MEDICAL CENTER**  
DALLAS, TEXAS



50864 (Rev. 06/08)

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