# ACRC TRIALS MEDICAL RECORDS RELEASE

**PATIENTS:** Please indicate the coordinator's name on the fax.

To: _____ Date: _____

_____

Physician or Hospital Name

City, State _____

Phone Number _____

Fax Number _____

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

✓ **Medical Summary Page / Most Recent Clinic Visit**

**Other:** _____

**Patient Information**

First Name: _____ Last Name: _____

SS#: _____ DOB: _____

Address (Street, City, State, Zip): _____

**Patient Signature:** _____

**Date:** _____

**Please send this information to:**

**ACRC Trials**

**Attention: Clinical Research Coordinator**

**5655 W. Spring Creek Pkwy, Suite 125, Plano, TX 75024**

**☎ 972-354-1520**

- ☐ **Fax Number: (972) 692-7713**
  - West Plano Medical Village – Family Practice
  - West Plano Medical Village – Pediatrics
  - West Plano Medical Village – Dermatology
  - Frisco Medical Village – Family Practice
- ☐ **Fax Number: (972) 692-7913**
  - Independence Medical Village – Family Practice
  - Medical City Plano – Family Practice
- ☐ **Fax Number: (469) 574-7822**
  - Carrollton Regional Family Center - Family Practice
  - Grapevine - Pediatric Dermatology
- ☐ **Fax Number: (512) 532-6801**
  - Southwest Medical Village – Family Practice