GARY W DUNCAN, MD
2840 Legacy Dr. Ste. 300
FRISCO, TX
75034
(972)867-8181
Fax (214)872-4937

RECORDS RELEASE AUTHORIZATION

Physician's Name: _____

Address: _____

_____

Phone: _____

Fax: _____

I hereby authorize and request you to release the complete history records in your possession concerning my illness and /or treatment to:

To: Dr. Gary Duncan
Address: 2840 Legacy Dr, Ste 300
Frisco, TX 75035
Phone: (972)890-9250
Fax: (214)872-4937

Reason: Moving Changing Doctors Second Opinion Other _____

Patient Name _____

Social Security Number _____ Date of Birth _____

Home Phone _____ Work or Cell Phone _____

Signature_____ Date _____