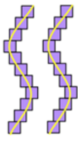

TESSERAE GENETICS

ANGELA SCHEUERLE, M.D.
F.A.A.P., F.A.C.M.G

Today's Date: ___________________

Requesting medical records TO:

____

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Send medical records FROM:

Dr. Angela Scheuerle
8624 Ferguson Road
P.O. Box 570494
Dallas, TX 75357

Patient Name: ___________________________________ DOB:_______________________

Please send a copy of the following records:

_____ All

_____ Physical Exams and Growth Charts

_____ Laboratory Tests

_____ Radiology Reports or Files

_____ Other (_________________________________)

By signing this form, I authorize you to release confidential health information about me, or my child, by releasing a copy of my medical records or summary of the protected healthy information to the person(s) or entity listed above.

____
Patient or Parent/Guardian Signature

____
Parent/Guardian Printed Name (if applicable)