

I hereby request release of my complete medical history records in your possession concerning my illness and/or treatment during the period of	
to	
From:	
	RIZWAN H. BUKHARI M.D., F.A.C.S., P.A. North Texas Vascular Center 3220 Gus Thomasson Road Suite 231 Mesquite, Texas 75150 Phone: (972) 885-8346 Fax: (214) 466-1976
То:	
	Doctor or Hospital
	Address
NAME	Date
ADDRESS	
SIGNATURE:	WITNESS:
RELATIONSHIP TO	PATIENT: