

# Elena Gurova, MD, PA

BOARD CERTIFIED INTERNAL MEDICINE

624 N Main Street, Cleburne, Texas, 76033  
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I, \_\_\_\_\_, hereby authorize  
the Medical Clinic of North Texas, PA to disclose the following information by mail to:

**Elena Gurova, MD PA**  
**624 N Main Street, Cleburne, TX 76033**  
**Phone: 817-645-5915, Fax: 817-645-5935**

**Patient's Name:** \_\_\_\_\_

**Patient's Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medical Records Requested:

- Office visit notes from the period of 9/2003 until 9/2006
- Imaging Study Reports (X-Rays, Ultrasound, CT, MRI, Mammogram, Bone Density, etc.)
- Cardiovascular reports (EKG, 2Decho, Stress Test, Spirometry, Vascular ultrasound, etc.)
- Consultation Reports (Cardiology, GI, Pulmonary, Neurology, etc.)
- Lab Reports
- Discharge Summary
- Other (must be specific)

This authorization is given freely for the purpose of transferring medical records with the understanding that:

Any and all records are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. A photocopy of fax of this authorization is as valid as this original.

I may revoke this authorization at any time, except where information has already been released.  
This authorization is valid for a one year period from the date it is signed.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date