



**Primary Medicine Of North Texas**  
**140 W. Lamberth Rd. Suite C**  
**Sherman, Tx 75092**  
**Phone: 903-868-0808**  
**Fax: 903-813-0953**

## **Disclosure Consent Form**

I \_\_\_\_\_ give permission for Primary Medicine of North Texas to disclose medical information to \_\_\_\_\_ .

I understand that without written documentation from myself, any and all personal information may be held by Primary Medicine of North Texas.

### **Information that may be disclosed:**

Lab results    X-Ray results    Prescription Information    Appointment Date

Authorization to pickup prescriptions from this office

Other \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness Signature** \_\_\_\_\_ **Date** \_\_\_\_\_