

# Notice of Request for Health Care Records

Formal Request for Access to Medical Documentation

## To Request Copies of Records,

Please provide the following information so we may locate your data correctly.

### Patient Information

- Name: [Your Full Name]
- Date of Birth: [MM/DD/YYYY]
- Address: [Your Mailing Address]
- Contact Number: [Your Phone Number]
- Email: [Your Email Address]
- Medical Record Number (if known): [Your MRN]

### Authorization

I understand that verifying my identity may be necessary before records are released. If additional documentation is required, please let me know.

### Health Care Regulation:

**Phone:** 512-438-5439 **Fax:** 512-438-3697

**Email:** [Health.Facilities.Enforcement@hsc.state.tx.us](mailto:Health.Facilities.Enforcement@hsc.state.tx.us)

**Mailing Address:**

Texas Health and Human Services Commission

Regulatory Services Division

Health Care Facility Enforcement (MC 1866)

P.O. Box 149347

Austin, TX 78714-9347

### To File a Complaint:

<https://www.texasattorneygeneral.gov/consumer-protection/ney-General>