

TESSERAÆ GENETICS

Today's Date _____

Requesting medical records FROM:

Send medical records TO:

Angela Scheuerle, M.D.

7777 Forest Lane

Suite B-240

Dallas, TX 75230

Patient Name _____ DOB _____

Please send a copy of the following records:

- All
- Physical Exams and Growth Charts
- Laboratory tests
- Radiology reports or files
- Other (_____)

Please call Dr. Scheuerle's office if any clarification is needed. If more than 15 pages, please send in the mail. Our phone number is (972) 566-6524. Our fax number is (972) 566-2024. Thanks for your help!

Patient or Parent/Guardian Signature

Parent/Guardian Printed Name (if applicable)