PLANO NEUROLOGY PA

4601 Old Shepard Place 406
Plano TX 750935279
972-867-3535 Fax: 972-867-3530

RECORDS RELEASE AUTHORIZATION

Patient's Name: _____

Date of Birth: _____

Soc. Security #: _____

Address: _____

_____

_____

Release From: _____

_____

Phone: _____ Fax: _____

Release To:

PLANO NEUROLOGY PA
4601 Old Shepard Place 406
Plano TX 750935279
Tel: **972-867-3535**
Fax: **972-867-3530**

I HEREBY REQUEST AND AUTHORIZE YOU TO RELEASE MY COMPLETE MEDICAL RECORDS, INCLUDING HISTORY AND PHYSICALS, CONSULTATIONS, PROGRESS NOTES, AND LABORATORY, PATHOLOGY AND RADIOLOGY STUDIES TO THE PROVIDER MENTIONED ABOVE.

ITEMS OF SPECIAL INTEREST:

_____

_____

_____

_____
Signature
(Parent or legal guardian if minor or if patient is unable to sign)