Authorization to Release Medical Records
FROM
Southwest Neurology, P.A.
Walter L. Taylor, III, M.D.
6701 Heritage Parkway, Ste 110
Rockwall, TX 75087
972-412-8700
972-412-9700 Fax

Dear Dr. Taylor:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark below)

Complete record
Records of care from _____ to _____ only
Records of care concerning the following condition(s)
To the following person:

Records to be sent to the following Physician:

Physician Name:_____

Street:_____

City_____ State_____ Zip_____

Office phone_____ Fax_____

The reasons or purposes of this release of information are as follows:_____
_____
_____

I understand that you will provide this information within (30) days, and there is no fee for furnishing this information when it is doctor to doctor.
Otherwise, the fee for medical records is $25.00

Signed: _____ by the Patient (or person legally authorized to consent on patient's behalf). Relationship if not patient:_____
Date: _____

Patient Name: **Date of Birth:**

Mail request to the above address.