Authorization to Release Medical Records
FROM
Southwest Neurology
6800 Heritage Pkwy, Suite 201, Rockwall, Texas 75087
Phone: (972) 412-8700
Fax (972) 412-9700

Dear Southwest Neurology, PA:

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

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

Records to be sent to the following Physician:

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

The reasons or purpose 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 providing this information when it is doctor to doctor. Otherwise, the fee for medical records is $25.00 for the first 1-20 pages and $.50 for each additional page.

Signed: _____ by the patient (or person legally authorized to consent on the patient's behalf). Relationship to patient: _____
Date :_____

Patient Name: _____ Date of Birth: _____

Mail request to the following address: _____

_____