Bryan Neurology Services, P.A.

Medical Records Request Form

Patient Name: _____

Street:_____

City: _____ State: _____ Zip:_____

Local Phone:_____ Cell Phone:_____

Date of Birth: _____SSN: _____

By signing this form, I authorize the person(s) or entity listed below to release a copy of my medical records, or a summary of my protected health information.

Doctor's Name: _____

Street: _____

City: _____ State: _____ Zip:_____

Phone: _____Fax: _____

Please release this information including complete medical records, radiology reports and laboratory studies to:

Randall Light, M.D.
Bryan Neurology Services, P.A.
2700 E. 29th St. Suite 305
Bryan, Texas 77802
(979) 776-4791 Fax: (979) 776-4785

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

_____

Limits on the information you may release subject to this Release Form are as follows:

_____

Patient Signature [or parent, guardian or legal representative]:

_____**Date: _____**

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial: _____Date_____