DALLAS NEUROSCIENCE, P.A.

GURU MOTGI, M.D.
Board Certified in Neurology
Clinical Neurophysiology & Electromyography
3503 W Wheatland Road Suite 200
Dallas Texas 75237
Tel: 214-943-3681 Fax: 214-941-9490

Medical Information Release Form
(HIPAA Release Form)

Name: _____

Date of Birth:_____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren) _____

[ ] Other_____

[ ] PCP/Ref MD/Other MD:
_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home _____

[ ] my work no. _____

[ ] my cell no. _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Signed: _____ Date: ____/____/_____
Witness:_____ Date: ___/____/_____