DALLAS
FIBROID CENTER

Medical Information Release Form

Patient 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_____

[ ] 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 [ ] my cell

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] Other _____

The best time to reach me is (day) _____ time_____

Signature: _____ Date:_____/_____/_____

Witness: _____ Date:_____/_____/_____