DALLAS
FIBROID CENTER

MEDICAL RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____/____/_____

This is Form intended as a Release of healthcare Information to:

Dallas Fibroid Center

FAX: 469-300-2733

[ ] I _____ (please print clearly) request and authorize the release of Healthcare Information including the diagnosis, records; physical examination, diagnostic imaging, labs and treatment plan rendered to me.

Should you have any questions, Please call my: [ ] my home [ ] my work [ ] my cell Number:_____ Alternate number:_____

If unable to reach me:
[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call
[ ] The best time to reach me is (day) _____ between (time)_____

Patient signature:

_____

Date: ____/____/_____ Time: _____AM/PM

Special Instructions/Request:

_____
_____
_____