THE GREATER HOUSTON
NEUROSURGERY CENTER, P.A.

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CLINICAL NEUROPSYCHOLOGIST

WILLIAM R. FRANCIS, JR., M.D., M.B.A.
ORTHOPEDIC SPINE SPECIALIST

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: Greater Houston Neurosurgery Ctr

_____

_____

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY # _____

I, _____ request that you release my medical records to:

_____

_____

_____

I am requesting:

_____ My entire chart
_____ Office dictation or date specific: _____
_____ Diagnostic testing
_____ Hospital records (H&P, OP reports, D/C notes, Consults)
_____ Pathology reports
_____ Other – Specify _____

(No cover page is necessary if a copy of this release is included)

Please forward any and all information regarding the examination, treatment, diagnosis and/or prognosis of myself. I understand that this may include information relating to Acquired Immunodeficiency Syndrome (AIDS), infection with HIV (Human Immunodeficiency Virus) and/or treatment of psychiatric conditions, alcohol abuse or drug abuse.

The foregoing authority shall continue in force and effect until revoked by me in writing. A copy of the original hereof shall be as effective as the original.

_____
Patient's Signature

_____
Date