Dallas Medical
Doctors of Internal Medicine

Sue Royappa, M.D., Rajashri Patil M.D., P.A.

8210 Walnut Hill Ln., Ste 306, Dallas, TX 75231, Phone 214-306-4030, Fax: 214-242-6758

Medical Release of Information Form

Patient's name: ____Date of Birth: ____________________

Social Security#:____________________________

Previous Name (if applicable):____

I request and authorize:

Doctor's Name: _________________________________

Address: _______________________________________

City, State, Zip: __________________________________

Phone Number: _________________________________

Please release the medical record of the above named patient to:

Dallas Medical, PLLC
8210 Walnut Hill Lane, Bldg 1 Suite 306
Dallas, TX 75231
214-306-4030, Fax: 214-242-6758

This request and authorization applies to: (initial appropriate line)

____Health Care information relating to the following treatment condition or dates of treatment:

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____All Health Care information including information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and /or alcohol use.

____All Health Care information excluding information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/ mental health or drug and /or alcohol use.

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Signature of patient or authorized representative Date

____

Relationship if signed by anyone other than the patient (parent, legal guardian, personal representative etc.)

This release expires 90 days after the date it is signed.