Dallas Medical
Doctors of Internal Medicine

Vijaya Mummadi, M.D.

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 You Are Requesting Records From: _____

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, PLEASE MAIL RECORDS

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

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

_____

_____

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

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

_____
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.