Medical Records Release Form

I, _____ (Patient Name) request and give permission to release medical records for the time period dating from_____ to _____.

These records are to be ***released to*** or ***released from*** (please circle):

Brazos Spine
Mukund Gundanna M.D.
3106 Texas Ave. S.
College Station, TX 77845

These records are to be ***released to*** or ***released from*** (please circle):

Name of Entity_____
Address: _____City_____State_____Zip_____
Phone Number: _____Fax Number: _____
Comments_____
_____

If faxing or mailing the Release of Medical Records Form to the medical clinic, include a copy of a photo ID such as a state-issued Driver's License, state-issued ID card, or passport.

Type of ID Presented: _____ ID #_____

_____	_____	_____
Patient Name (printed)	Date of Birth	Social Security #
_____	_____	
Patient's Signature	Date	

Mukund I. Gundanna, M.D.
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