THOC, P. A.
DENNIS BIRENBAUM, M.D.
MUKESH DELVADIYA, M.D.

REQUEST AND CONSENT FOR RELEASE OF MEDICAL RECORDS

Date: _____

I hereby authorize (name of office/clinic)
_____

To release the following information from my medical record:

Patient Name: _____
Address: _____
Date of Birth: _____ SSN: _____

Information to release:
☐ Dates of treatment, from _____ to _____
☐ Information relating to the following treatment: _____
_____
☐ Entire medical record

Information is to be released to:
THOC, P. A. (DENNIS BIRENBAUM, M.D.)
(MUKESH DELVADIYA)
10 Medical Parkway Prof. Plaza #3 Suite 106
Dallas, TX 75234
Phone (469) 453-5500 Fax (972) 243-1285

Purpose of disclosure: _____

Patient/Representative Signature: _____
Relationship: _____
Date: _____
Witness Signature: _____

(Please mail or fax the requested information)
THOC, P. A. 10 Medical Parkway Prof. Plaza #3 Suite 106 Dallas, TX 75234
Phone: (469) 453-5500 Fax: (972) 243-1285