Brain and Spine Center of Texas, L.L.P.

Rebecca E. Stachniak, M.D.

Release of Medical Information

Patient Name:_____

Date of Birth: _____

Social Security Number:_____

_____
Street Address

_____
City, State and Zip Code

I expressly request that the designated record custodian disclose my full and complete protected medical information to:

_____
Name of entity requiring the information

_____
Street Address

_____
City, State and Zip Code

_____
Phone and Fax number

This disclosure should include:

All records_____

Specify records_____

Billing records_____

For the period _____to _____

_____ _____
Patient Signature Date