

DFW Pediatric Neurology

Dr. Mary Oladunni Baiyeri, MD, PA

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Patient Release of Medical Records Form

Patient's name: _____ Date of Birth: _____

Address: _____

Telephone #: _____ Alternate#: _____

Please release my medical records from:

Name of Provider: _____

Phone#: _____ Fax# _____

Providers Address: _____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE TO DR. MARY BAIYERI, MD, PA.

Patient/Legal Guardian Signature

Date