PATIENT RELEASE OF MEDICAL RECORDS

Patient's Name: _____ request and give my permission to release my Medical Records for the time period dating from _____ to _____ from the following medical clinic:

Joseph P Behan, M.D.
8160 Walnut Hill Lane, Ste 328/209
Dallas, TX 75231
214-987-1195
214-987-1786 FAX

The Medical Records as listed above are to be released to:

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone Number: _____

Fax Number: _____

Comments:

_____

_____

_____

_____ _____

Printed Patient Name Date of Birth

______________________________ __________________________

Patient's Signature Today's Date