NEUROLOGY CENTER
FOR EPILEPSY AND SEIZURES

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Suite 101 B, Building B
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MEDICAL RECORDS REQUEST

TO: _____ **FROM:** _____

I, _____ DOB: _____ authorize Neurology Center for Epilepsy and Seizures to request records on my behalf from:

Physician/Office/Facility: _____

Address: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED:

_____

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____