Bryan Neurology Services, P.A. Medical Records Request Form

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ocal Phone:	Cell l	Phone:
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	uthorize the person(s) or enti mmary of my protected heal	ity listed below to release a copy of the information.
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HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest

of my medical records. Initial: _____Date____