Medical Release Form

I hereby authorize Amor Mehta M.D. Neurology Center for Epilepsy and Seizures to request patient information from:

Name: ____

Address: ____

Telephone: (_____)_____________ Fax: _________________________

Information to be released:

____

____

Patient Name:____________________ D.O.B______________________

______________________________ ___________________________

Signature of Patient/ Caregiver Date

______________________________ ___________________________

Signature of Parent/Guardian Date