TOWN & COUNTRY CROSSING
ORTHOPEDICS

Brett A. Taylor, M.D.

Date: _____/_____/_____

To: _____

_____

I authorize and request you to release my medical records to:

BRETT A. TAYLOR, M.D.

ATTN: LORI
FAX: 636-686-9193
PHONE: 636-227-8226

884 WOODS MILL RD.
SUITE 201
ST. LOUIS, MO 63011

PLEASE SEND:
_____ COMPLETE MEDICAL RECORD
_____ OPERATIVE REPORT (SPINE ONLY)
_____ X- RAY REPORTS (SPINE ONLY)
_____ X-RAY FILMS TO INCLUDE MRI, CT, CT/MYELOGRAM, DISCOGRAM

PATIENT'S NAME: _____
LAST FIRST MI

D.O.B.: _____/_____/_____

SIGNED: _____
PATIENT OR NEAREST RELATIVE

_____ _____
WITNESS RELATIONSHIP