Neurologic Associates

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Authorization to Release Medical Records

Patient Name: _____ Date(s) of Service: _____

Date of Birth: _____ Social Security Number: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above-named patient.

Patient Information Needed For:

- ☐ Continuing Medical Care
- ☐ Legal Purposes
- ☐ Personal Use
- ☐ School
- ☐ Social Security/Disability
- ☐ Other_____

Information To Be Released:

- ☐ Consultation Report
- ☐ History and Physical
- ☐ Laboratory/Radiology Reports
- ☐ Office Visit Reports

TO:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State and Zip Code)

FROM:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State and Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date:_____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Representative

_____

Relationship to Patient