

Neuroscience Associates

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Medical Record Release

Patient Name: _____ Date of Birth: _____
(Please print) Social Security No: _____

Authorization for medical information regarding the above patient to be released.

From: _____
Name
Street Address
City State Zip Phone#

To: _____
Name
Street Address
City State Zip Phone #

Purpose for release _____

Information Requested to be released:
Chart Notes: _____ Hospital records: _____
X-ray films: _____ X-Ray results: _____
Lab results: _____ All Records: _____
Itemized billing: _____

I hereby consent to release the above stated information.

Signature: _____ Date: _____

Relationship to Patient: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Signature: _____ Date: _____

Relationship to Patient: _____

This authorization is valid for 180 days and may be revoked at any time by written request.

Date Mailed or Faxed: _____ Date Hand Carried: _____