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:_____

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