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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