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Adult Neurological & Sleep Disorders
Consultation by Referral Only

Authorization for Release of Medical Information

Patient Name: _____ _____ D/O/B: _____ SS#: _____

Previous Name: (if applicable): _____

Address: _____

By signing this form, I hereby authorize: _____

To disclose personal health information, as described below to: _____

_____
(Name & Address of Person or Organization to which disclosure is to be made)

For the following purpose: _____

For the following dates of service (must be completed): _____

Select portions of information requested

_____ Entire Record
_____ Consultation
_____ Revisit Office notes
_____ Labs only
_____ Imaging/Radiology
Other: _____

This authorization expires: _____ or unless otherwise specified, 90 days from this date signed below and covers ONLY treatment for the dates specified.

I, the undersigned, have read the above and authorize the staff of the disclosing facility names to disclose such information as herein contained. I understand that this authorization may be withdrawn by me by notifying the provider in writing at any time, except to the extent that action has been taken in reliance upon it. The provider is released and discharged of any liability and the undersigned will hold the provider harmless, for complying with the "Authorization for Release of medical Information".

_____ _____
Signature of Patient / Legal Representative Date

_____ _____
Printed Name Relationship / Type of Authority

Note: This document must be made part of the patient's medical record. A copy of this document is available to the patient or legally authorized representative (if requested).