

# Authorization to Release Medical Records & Information Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ SS# \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Number 1.**

I, \_\_\_\_\_ hereby authorize the following physician/clinic:

\_\_\_\_\_ to release medical records and information to **Clinical Neurology Specialists**.

Number 1 is for CNS to obtain your previous medical records from a specific medical facility or doctor.

## **Number 2.**

I, \_\_\_\_\_ hereby authorize **Clinical Neurology Specialists** to communicate my health care to the following family member/personal representative (PR):

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

d. \_\_\_\_\_

Number 2 is authorization for CNS to speak to your family or PR about scheduling and your health condition.

## **Number 3.**

I, \_\_\_\_\_ hereby request my medical records and authorize **Clinical Neurology Specialists** to release my medical records to myself and/or family member or personal representative listed: \_\_\_\_\_

Number 3 is authorization for CNS to release your medical records to yourself and/or designated person. Please allow up to 30 days from the date of your request to have your medical records sent to your address listed above.

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Do you give permission to **Clinical Neurology Specialists** to obtain and/or discuss your medical condition, examination or diagnosis with your primary care provider (PCP) and referring licensed health care provider (at times these may be two different providers):

Primary Physician  Yes  No Physician's Name: \_\_\_\_\_  
Referring Provider  Yes  No Referring Provider: \_\_\_\_\_

Please list any family members you **DO NOT** wish CNS to discuss your health condition with:

a. \_\_\_\_\_

b. \_\_\_\_\_

Do you give **Clinical Neurology Specialists** permission to send this information electronically by fax or carrier?

YES  NO \_\_\_\_\_ Patient Initial

In the event we have to contact you and you are not home, may we leave a message on your machine/voicemail box or leave a message with your contact person/family member?

YES  NO \_\_\_\_\_ Patient Initial

Name of Contact Person: \_\_\_\_\_

Please note that unless revoked by patient in writing, this authorization release shall remain valid indefinitely.

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Patient Name (print)

Patient Name (signature)

Date