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 **C**linical **N**eurology **S**pecialists.

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

Number 2.

☐ I, ______________________________ hereby authorize **C**linical **N**eurology **S**pecialists 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 **C**linical **N**eurology **S**pecialists 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.

Do you give permission to **C**linical **N**eurology **S**pecialists 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 **C**linical **N**eurology **S**pecialists 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

Las Vegas: * 7751 W. Flamingo Rd. Ste A-100 * Las Vegas, NV 89147 * Phone: (702) 804-6555 * Fax: (702) 804-1273
Henderson: * 1691 W. Horizon Ridge Ste 100 * Henderson, NV 89012 * Phone: (702) 804-1212 * Fax: (702) 804-1273