THE CENTER FOR NEUROLOGY AND NEUROPHYSIOLOGY, P.A.

Release of Medical Records

I hereby authorize The Center for Neurology and Neurophysiology, PA to send or obtain any medical information needed for my care.
I understand that the specific information to be released may include all physician records as well as treatment of drug or alcohol abuse, mental illness, or communicable disease; this does include Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information had been made prior. You have a right to limit medical information we disclose to someone involved in your care, if you wish to do so please write down any persons or facilities that you do not want to receive information and the information that you want limited. Please note that the physician does not have to agree to your request.

Restrictions List

Please fill out below any persons that may get information on your behalf.

Authorization List

Name of Person	**Relationship**

I may be contacted for appointments in the following manner (check all that apply)		
	Message with detailed information	**Message with call back number only**
Home Phone #	☐	☐
Cell Phone #	☐	☐
Text Message #	☐	☐
Work Phone #	☐	☐
Email	☐	☐

Signature	Date
DOB	SS#

Printed First Name _____ Printed Last Name _____

Save As Print