NATIONAL CAPITAL NEUROSURGERY

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Date Requested:_____

Patient:_____

Account #:_____ Tel#:_____

I authorize National Capital Neurosurgery to release my medical information to

_____
(Name of recipient)

at:_____ _____
(Street Address) (City, State and Zip code)

Telephone:_____ Fax:_____

Information to be released (check all that apply)

☐All Progress Reports ☐Surgical Reports

☐Other (specify_____)

Records from: ___/_____/_____ to ___/_____/_____

Purpose or need for disclosure (check all that apply)

☐2nd Opinion ☐Personal* ☐Physical Therapy ☐Pain Management

☐Legal ☐Worker's Compensation ☐Other_____

_____ _____
(Patient Signature/Relationship to Patient) (DOB or SSN)

_____ _____
(Street Address) (City, State and Zip code)

_____
(Custodian of Records Signature)
*There will be $15.00 charge assessed when the purpose of disclosure is personal