Associated Neurological Specialties & Sleep Disorder Center

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____/_____/_____
PRINT NAME **DOB**

(_____) _____-_____ _____
PHONE **ANS PHYSICIAN**

I, do hereby authorize: _____, to release
Physician/Facility & Phone/Fax

____ Discharge Summary	____ Laboratory Reports	____ Sleep Study
____ History & Physical	____ Radiology Reports	____ Entire Chart
____ Progress Notes	____ EEG Report	____ Other:

Release of Medical Records: _____
Person/Physician/Facility

_____
Address

_____
Phone & Fax

I understand that I may revoke this consent at any time except to the extent that action has already been taken, In any event, this authorization expires automatically 90 days from the date of signature or as otherwise specified. Reports may include information on drug, alcohol, psychological, HIV/AIDS, or communicable treatment- I waive the privilege of confidentiality of such information. **A FEE OF $25 IS CHARGED FOR PERSONAL USE OF MEDICAL RECORDS AND ¢.50 FOR EVERY PAGE AFTER THE FIRST $25.** Completion of affidavit is additional $15.

_____ _____/_____/_____
SIGNATURE OF PATIENT/GUARDIAN **DATE**

_____ _____/_____/_____
WITNESS **DATE**