NEUROLOGY
SPECIALISTS

Authorization for Release of Information

Patient Name: **SSN:**

I authorize _____ at
(Name of physician or authorized facility)

_____
(Street address)

_____
(City, State, Zip)

_____
(Telephone and Fax numbers)

to release to *Neurology Specialists, PA* the following information from my medical records.

_____ History and physical, consult reports
_____ Discharge summary
_____ Medication sheet
_____ Radiology reports
_____ Echocardiogram report
_____ Holter monitoring report
_____ Coronary catherization reports
_____ Angiogram reports
_____ Stress test reports
_____ EKG reports

_____ Laboratory test results
_____ Microbiology report
_____ Pathology reports
_____ Colonoscopy report
_____ Mammogram report
_____ Pulmonary function test result
_____ Arterial blood gases
_____ Bronchoscope report
_____ Others
_____

The requested information may be delivered to *Neurology Specialists, PA* by mail, facsimile or any other means authorized by me or permitted by law. I understand that I may revoke this consent at any time before the information has been released. This authorization expires one (1) year from the date below.

Any alcohol or substance use information, HIV or AIDS-related information released is protected by Federal Regulations and may not be re-disclosed without an explicit written consent of the undersigned.

Patient Signature: _____ OR

Signature of Legal representative: _____ ___ _____
(Copy of Power of Attorney for Health Care must be attached)

Date: _____

Mailing Address: 9730 Commerce Center Court, Fort Myers, Florida 33908