AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NEUROLOGY CLINIC, P.A.
1333 Pine Street
Melbourne, FL 32901
(321) 984-9400 Fax (321) 984-0150

Patient Name:_____

Date of Birth:_____ SS# _____ Phone:_____

Patient Address:_____

I authorize Neurology Clinic to release medical information from my medical records

(select one) **TO / FROM**_____

Address_____

Phone_____ Fax:_____

Specific documents to be released:

( ) All Records	( ) Face Sheet	( ) Discharged Summary
( ) History/Physical	( ) Operative Reports	( ) Consultation
( ) Labs	( ) Radiology Reports	( ) Progress Notes
( ) Physician Orders	( ) Cardiology Reports	( ) Medications
( ) Psychiatric	( ) HIV / AIDS	( ) **Specific Dates**_____

( ) **OTHER**_____

( ) **Hand Carry** ( ) **Mail** ( ) **Fax**_____

Purpose for information:

( ) Continued Medical Care ( ) Insurance ( ) Personal

This request is authorized to include any federal and/or state protection under Florida Statues 394.459 (9) Psychiatric information, 397.053/396.112 Drug and Alcohol information, 381.609 HIV and AIDS related conditions and/or 397.50 (3) records of minor client.

Note to requesting party: Florida statue has established guidelines and cost rates for the copying of records. Your signature on this form indicates your knowledge of this statement.

I understand that I have the right to revoke this authorization at any time. If I decide to do so, it must be done in writing and be presented to the Medical Records Department.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I herby release Neurology Clinic and their employees, agents, officers and affiliated, from any and all liability, responsibility, claim and damages which may result from the release of information authorized by the consent for release of information.

Signed:_____ Date_____

Witness_____ Date_____