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South Florida Neurology Associates, P.A.
Diplomates, American Board of Psychiatry and Neurology

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: ______________________

I, ____, authorize the release of my medical records to:
(Patient's Name)

To: ____

Fax #: ____ Phone #: ____

Address: ____

(Please list doctor's name, address & fax, or patient's name & address if being released to patient**)**

Please send the following medical and/or related records as indicated for the named patient above as soon as possible as they will soon be seen or have been seen in this office.

Include:
- ❑ Office Notes
- ❑ Diagnostic Tests
- ❑ Medication List
- ❑ Labs
- ❑ Other: __________________________

Please fax the records to: 561-939-0339

If mailed, please send to:
South Florida Neurology Associates, P.A.
1601 Clint Moore Road, Suite 120
Boca Raton, FL 33487

It is understood:

- That the recipient of the protected health information under this authorization should not re-disclose the information without a written authorization.
- Health Care Provider will not condition the provision of care or receipt of benefits on the signing of the authorization.
- Patient will receive a copy of the completed authorization form upon request.
- Patient may revoke this authorization by requesting in writing.

This authorization expires: (choose one)
- ❑ 30 days from above date
- ❑ 1 year from above date
- ❑ immediately after this request is fulfilled

___________________________________ Patient's Signature

___________________________________ Patient's Date of Birth

___________________________________ Printed Patient's Name

___________________________________ Patient's Address