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

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REQUEST FOR PATIENT MEDICAL RECORDS

Date: _____

To: _____

Fax #: _____ Phone #: _____

Patient's Name: _____ DOB: _____

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