CLINICAL NEUROLOGY P.C.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO WHOM IT MAY CONCERN:

PATIENT NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____ SS# _____

I GIVE PERMISSION/AUTHORIZATION TO RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

ADDRESS: _____

_____

TEL# _____ FAX#_____

TO: **CLINICAL NEUROLOGY PC**
19455 Deerfield Ave #211
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I UNDERSTAND THAT THESE RECORDS MAY CONTAIN RFERENCES TO MENTAL HEALTH, SUBSTANCE ABUSE, OR HIV/AIDS RELATED INFORMATION.

_____
SIGNATURE OF PATIENT/PARENT/GUARDIAN

_____
WITNESS

_____
DATE