



Neurology
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MEDICAL RECORD RELEASE FORM

I authorize (Request from Name): _____

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

To release any information including the diagnosis and medical records of any treatment or examination rendered to me during the period from _____ to _____.

To include Federal and State protected information under Florida Statue 394.459 (9) Psychiatric Information Florida statue 394-053 and Florida statute 396-112 Drug and/or Alcohol Abuse Information and Florida Statute 381-609 (2) Human Immunodeficiency Virus test results (Aids and related conditions).

I understand and direct that this authorization remain in effect until I revoke it in writing. I also release your office or facility and its employees from all liability that may arise from the release of this information as I have directed.

Patient Name Printed _____ D.O.B ____/____/____

Patient Signature: _____ Date: ____/____/____

Authorized Agent Signature _____ Date: ____/____/____

******* PLEASE SEND RECORDS STAT*******