PATIENT REQUEST FOR RECORD RELEASE

POLIN NEUROSURGERY

Last Name _____ First Name_____ MI___

Date of Birth_____ Phone Number _____

Types Of Records To Be Released:

____***Complete Record***

-OR-

Most Recent

____Chart Note (last 6 months) _____Hospital Record _____Imaging Report Lab Report

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Release Records To:

Name: _____

Address: _____

Fax: _____

Other: _____

Why are we sending the records?

___Personal Use ___Legal/Litigation ___Insurance ___Transition/Continuation of Care

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I expressly and voluntarily authorize disclosure of the above medical records for the purpose stated above. I further understand that I am not giving permission for any disclosures other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This release is effective for 12 months from the date signed, unless otherwise specified as follows_____.

I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained from me, or unless such disclosure is specifically required by law.

_____ _____ _____

Signature of Patient or Legal Representative Relationship to Patient Date

_____

Printed Name of Patient or Legal Representative