THE NEUROLOGICAL INSTITUTE, P.A.

7000 Shannon Willow Rd. Charlotte, NC 28226 (P) 704-372-3714 (F) 704-333-4601

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_____

Date of Birth:_____

I, _____, hereby authorize The Neurological Institute and/or its agents:
(Check one)

_____ To release information regarding my medical care and/or treatment to:
_____
_____
_____
Or

_____ To request information regarding my medical care and/or treatment from:
_____
_____
_____

I understand that I may revoke this consent at any time, except to the extent that action has already been taken.

_____ _____
Patient Signature (parent, guardian, caretaker) **Date**

[if other than patient signature, relationship: _____]

_____ _____
Witness Signature Date

MAIL FORM:
Medical Records
The Neurological Institute
7000 Shannon Willow Rd.
Charlotte, NC 28226

FAX FORM: 704-333-4601, Attention: Medical Records