THE NEURO CENTER | Advanced Neurology & Sleep Medicine. Personalized care.

MEDICAL RECORDS RELEASE FORM

Patient Name:____________________Date of Birth: ____________
Last 4 of your social security number___________

A:) I authorize The Neuro Center to RELEASE copies to:
Name:____
Address:____
City, State & Zip:____
Phone:________________________Fax:_________________________________

B:) I authorize The Neuro Center to OBTAIN copies from:
Name:____
Address:____
City, State & Zip: ____
Phone:_________________________Fax:____________________________

Check the information that may be release. (Please note that only records that have been ordered by our office may be released.

___Complete Chart **__Lab Results** **__Sleep Study Results**
__CT/MRI Results **__EEG Results** **__ Driveable**
__Neurotrax **__EKG/TTE/TEE** **__ Lumbar Puncture**
__CTA (Head & Neck) **__Carotid Ultrasound** **__Emergency Room Record**
__Others____________ **__Neuropsychological Testing**

I hereby authorize this practice to release my medical records, including, but not limited to all the above. By signing this consent I completely release the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. I also understand this authorization is only valid for 12 months.
Patient/Patient Representative's Signature:______________________Date:____________

PHONE: 678-961-0733 FAX: 678-961-0744
1485 JESSE JEWELL PARKWAY NE, SUITE 240
GAINESVILLE, GA 30501
drcobb@georgianeurocenter.com **www.georgianeurocenter.com**