Midtown Neurology

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Authorization for Release of Information

_____ _____
Patient Name Date of Birth

Release To: _____

Fax/Address:_____

_____

_____

You are hereby authorized to release copies of:

X ray reports____ Labs ____ Billing ____ Office Notes ____ All Records ____

This includes the records of the patient's treatment at Midtown Neurology, P.C. and shall include any records that may contain information regarding psychiatric treatment and/or drug & alcohol usage or treatment for such usage or abuse, and/or HIV/AIDS confidential information.

Midtown Neurology, P.C., its officers, directors, associates, and agents are hereby released from any legal liability that may arise from the release of information requested.

I understand this consent is subject to revocation at any time by the undersigned except to the extent that action has already been taken in reliance upon this consent. In any event, this consent will expire without revocation 90 days from the date signed.

This consent is executed on the _____ day of _____, 20_____.

_____
Signature of Patient

If consent is necessary from a person authorized to give the consent other than the patient:

_____ _____
Signature of patient's representative Relationship to patient

This consent shall have a duration no longer than is reasonably necessary to effectuate the purpose for which it is given.