Neurology Specialists of the Treasure Coast, P.A.
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Phone (772) 888-2611 Fax (855) 667-1903

Medical Records Request
Authorization for Use, Disclosure, and Release of Health Information

Date _____

Patient _____dob_____

The above named patient authorizes Neurology Specialists of the Treasure Coast, P.A. to: (Choose one)

❑ Request their Medical Records from: OR ❑ Release their Medical Records to:

_____
(Full Name of Provider, Hospital, Facility or Person) (Phone Number)

_____
(Street Address) (Fax Number)

_____
(City, State and Zip Code)

Please include dates of service from: _____ through _____

❑ Office Notes
❑ Neurology Consultation Report(s)
❑ Hospital H&P/Discharge Summary
❑ Lab Results
❑ Pathology / OP Reports
❑ EEG / Sleep Study Reports
❑ MRI and CT Reports of the Brain and Spine
❑ Echo, Carotid US, TEE
❑ EMG / NCV

❑ Other_____

My Records may contain the following and, unless crossed out and initialed, I specifically authorize their release:
HIV/AIDS/STD Records - Drug/Alcohol Records - Tuberculosis Records - Pregnancy Records - Mental Health Records

_____ _____
Patient Signature (or Legal Representative) Date

_____ _____
Relationship to Patient Date

Pursuant to the Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individual not subject to HIPPA and may no longer be protected by HIPPA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time in writing, to the address listed above provided that the information has not yet been released. This authorization expires in six (6) months unless another date is written here_____. This release of information is for continuity of care, unless otherwise noted:_____.

❑ Please fax records to (855) 667-1903 **❑ This is for Immediate Patient Care**