NEUROLOGY OFFICE

JOSEPH KANDEL, M.D.

& ASSOCIATES

MEDICAL RECORDS RELEASE/REQUEST

I, _____ Date of Birth_____

(print name)

Phone #_____ Email _____

Give permission for **Neurology Office, Joseph Kandel MD & Associates** to **request** or **release** my records for the purpose of:

( ) Continuing Care ( ) Personal Use ( ) Insurance ( ) Legal or Other:_____

For dates of service from_____to_____ or ( ) ALL DATES. This authorization will expire 2 years following the last date of service.

A copy or summary of ( ) **COMPLETE MEDICAL RECORDS** OR the following:

( ) **Progress Notes/Consultation Reports**

( ) **Biopsy Reports/Surgical Procedures**

( ) **Lab Reports**

( ) **EEG/EMG Reports**

( ) **MRI Reports and/or CD**

( ) **X-Ray, CT or other Radiology Reports**

Please initial to allow the designated facility to disclose information protected under federal law relative to: ( ) psychiatric care, ( ) drug and/or alcohol treatment, or ( ) diagnosis or information specific to HIV, AIDS or ( ) Sickle Cell Anemia.

Records to be received from or received to:

Name:_____

Address:_____ Phone:_____ Fax:_____

I have read this authorization and understand what information will be disclosed by Neuroscience and Spine Associates. I also understand that I have the right to revoke this authorization, in writing, at any time.

_____ _____

(signature) (Date)