

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Request Date: _____

Patient Name: _____ DOB: _____

Contact Phone No. _____

• **PLEASE CHECK ONE OF THE FOLLOWING REQUESTS:**

I authorize Pediatric Neurologists of Palm Beach to **RELEASE** my medical records to (circle):

Provider/Facility/Guardian _____

Address _____

City, State, Zip _____

Phone# / Fax# _____

I authorize Pediatric Neurologists of Palm Beach to **OBTAIN** my medical records from:

Provider/Facility _____

Address _____

City, State, Zip _____

Phone# / Fax# _____

FAX THIS RELEASE TO: 561-795-5004 OR EMAIL: STAFF@PEDINEUROLOGISTS.COM

SPECIFY IF YOU WANT RECORDS SENT TO FAX OR ADDRESS ABOVE _____

REQUEST FOR: Transfer Care _____ Other- specify _____

TYPE OF RECORDS REQUESTED: Entire Records _____ Notes _____

Diagnosis Letter (school) _____ Imaging _____ EEG/VEEG _____

Labs _____ *Other (specify) _____

I am authorizing release of all my records. If the person or facility receiving this information is not a healthcare or medical provider covered by privacy regulations, the information stated above could be re-disclosed (ie: school etc). The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Your provider can charge you a fee for the requested records. Charges for personal use \$1.00 per page, up to 25 pages then \$0.25 every page after that. There will be NO Charge to send your records to another provider.

Patient or Guardian Signature _____ Date: _____



Edwin Liu, M.D.

Bernardo Flasterstein, M.D.

Farjam Farzam, M.D.

Abigail E. Ley, M.D.

Novette Green, D.N.P.

Michelle L. Jampol, A.R.N.P.

Alyssa P. Ausnehmer, A.R.N.P.

**12959 Palms West Drive
Suite 120
Loxahatchee, FL 33470**

**11310 Legacy Avenue
Palm Beach Gardens, FL 33410**

**150 SW Chamber Court
Suite 203
Pt St Lucie, FL 34986**

**Phone 561-753-8888
Facsimile 561-795-5004
www.pedineurologists.com**