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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# _____

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.

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

Patient or Guardian Signature _____Date: _____

*This release expires 30 days from date of signature and can be revoked at any time with notification in writing.