Center for NEUROSCIENCES
2450 E. River Road • Tucson, AZ 85718 • Phone: 520.795.7750 • Fax: 520.320.2155

AUTHORIZATION FOR RELEASE OF *or* AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Note: All information must be provided – incomplete forms cannot be processed

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PURPOSE OF RELEASE: ☐ Continuity of Care ☐ At the Request of the Individual ☐ Other:_____

☐ **FMLA/Disability** *Please note there is a $25 charge to complete this paperwork; there is a $25 annual charge each year thereafter.*

☐ **Two-way release – records may be released both to/from either party.**

RECORDS TO BE RELEASED FROM:

Name: _____

Address: _____

City, State, Zip Code: _____

Fax Number: _____

RECORDS TO BE RELEASED TO:

Name: _____

Address: _____

City, State, Zip Code: _____

Fax Number: _____

☐ **Check here if records need to be sent.**

Information to be released: (circle any that apply) CONSULTATIONS & OFFICE VISITS NEUROPHYSIOLOGY

LABORATORY HOSPITAL CONSULTS & PROCEDURES RADIOLOGY ❒ Report Only ❒ CD with Image

OTHER: _____

HIV/AIDS Information

❒ **Include this information in the release**

❒ **DO NOT release this information**

Dates of records to be included: FROM: _____ TO: _____ OR ☐ **PRESENT**

PLEASE NOTE:

- Center for Neurosciences will not base treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed.
- You may change or revoke this request by sending a written request to Center for Neurosciences at the address above.
- Information disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- Records will be sent by mail within 14 business days of receipt of this request.

I have read and understand the above information. My signature authorizes the disclosure of the information described. This Authorization will expire two years from the date of this signature.

_____ _____

Signature of Patient, *Personal Representative or Parent/Guardian Date

Relationship if the person signing is other than the Patient: _____

If this request is made by a Personal Representative, we will require verification of the authority of that Personal Representative before this request will be considered complete.

OFFICE USE ONLY

Identity verified by: _____

Revised: 12-21-2021