ROCKY MOUNTAIN NEUROLOGY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

RECORDS REQUESTED FROM:

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PLEASE SEND RECORDS TO:

Rocky Mountain Neurology, PC
10103 Ridge Gate Parkway, Suite 125
Lone Tree, CO 80124
Phone 303-790-8899
Fax 303-790-2810

PLEASE SEND THE FOLLOWING:

______ All progress reports

_____ Lab tests

______ Neurobehavioral/
Neuropsychiatry testing *

_____ ALL RECORDS *

_____ EMG/EEG/VEP results

______ MRI results

_____ Other: ________________________________

*** Please note that to provide Neurobehavioral/Neuropsych testing results, that line MUST be checked. ***

The purpose of this release is for medical treatment. This authorization will expire one year from the date it is signed. I understand that: 1) I have the right to revoke this authorization in writing, but if I do, it will not have any effect on actions taken prior to the date that written revocation is received; 2) signing this authorization is voluntary; 3) the information used or disclosed to someone who is not a health care provider or a health plan may no longer be protected by federal privacy regulations and may be forwarded by that party without your consent; 4) I may have a copy of the information disclosed.

PATIENT INFORMATION:

____ ________________
Patient name: PRINT Patient date of birth

____ ________________
Patient or patient guardian signature Date

____ ________________
Witness Date