ROCKY MOUNTAIN NEUROLOGY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

RECORDS REQUESTED FROM:

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

PLEASE SEND TO:

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PLEASE SEND THE FOLLOWING:

______ All progress reports

______ Lab tests

______ Neurobehavioral testing *

______ ALL RECORDS*

______ EMG/EEG/VEP results

______ MRI results

_____ Other: ____________________

*** Please note to provide Neurobehavioral/Neuropsych testing results, the Neurobehavioral/Neuropsych 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