Medical Records Release Request

Name: ____ **DOB:** __________________

At the request of the above patient, please release the following medical information necessary for neurological treatment to **Abington Neurological Associates, Ltd.**

- Office visit notes
- Hospital visit records
- Diagnostic tests (e.g. radiology, sonography, electrodiagnosis)
- Laboratory reports (e.g. blood tests, biopsy, cytology)

Please fax the above information to **215-957-9254** or mail to **2325 Maryland Road, Suite 120, Willow Grove, PA 19001.** If you have any questions, please call Abington Neurological Associates, Ltd. at **215-957-9250.**

I authorize release of records pertinent to my neurological care at Abington Neurological Associates.

Patient signature: ___________________________________ **Today's date:** ______________

Requesting provider:

☐ James M. Burke, MD	☐ John S. Khoury, MD	☐ Jaime Brisendine, PA-C
☐ James H. Cook, MD	☐ Brad C. Klein, MD	☐ Cynthia Ferrari, PA-C
☐ Steven D. Factor, MD	☐ Kandan Kulandaivel, MD	☐ Christopher Hillery, PA-C
☐ Dan J. Gzesh, MD	☐ Kartik Sivaraaman, MD	
☐ Lee J. Harris, MD	☐ David C. Weisman, MD	

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