

# 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 **1151 Old York Road, Suite 200, Abington, PA 19001**. If you have any questions, please call Abington Neurological Associates, Ltd. at **215-957-9250**.

### Requesting provider:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> James M. Burke, MD   | <input type="checkbox"/> Lee J. Harris, MD      | <input type="checkbox"/> Kartik Sivaraaman, MD     |
| <input type="checkbox"/> James H. Cook, MD    | <input type="checkbox"/> John S. Khoury, MD     | <input type="checkbox"/> David C. Weisman, MD      |
| <input type="checkbox"/> Steven D. Factor, MD | <input type="checkbox"/> Brad C. Klein, MD      | <input type="checkbox"/> Christopher Hillery, PA-C |
| <input type="checkbox"/> Dan J. Gzesh, MD     | <input type="checkbox"/> Kandan Kulandaivel, MD | <input type="checkbox"/> Irina Uritsky, CRNP       |

### Patient Consent

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

This includes specific permission to release the following sensitive information:

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychological, psychiatric, or other mental impairments<br>(excludes "psychotherapy notes" as defined in 45 CFR 164.501)                             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Drug abuse, alcoholism, or other substance abuse   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV or sexually transmitted diseases |

Patient signature: \_\_\_\_\_ Today's date: \_\_\_\_\_