Medical Records Release Request

Name: _____ **DOB:** _____

Patient instructions: To obtain medical records from another facility, we may need to send a signed authorization granting them permission to release records to us. Please provide your signature below. You can also specifically permit or forbid the release of information regarding mental health, substance abuse, and HIV/AIDS.

At the request of the patient named above, 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)
- Other:

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:

☐ James H. Cook, MD	☐ John S. Khoury, MD	☐ Diana Z. Li, MD
☐ Steven D. Factor, MD	☐ Brad C. Klein, MD	☐ Kartik Sivaraaman, MD
☐ Dan J. Gzesh, MD	☐ Kandan Kulandaivel, MD	☐ David C. Weisman, MD
☐ Lee J. Harris, MD	☐ Lisa Leschek-Gelman, MD	☐ Sarah Smith, 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:

☐ Yes ☐ No	Psychological, psychiatric, or other mental impairments (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
☐ Yes ☐ No	Drug abuse, alcoholism, or other substance abuse
☐ Yes ☐ No	Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV or sexually transmitted diseases

Patient signature: _____ **Today's date:** _____