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:

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

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