Tallahassee Neurology Specialists, P.L.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:

Last: ______________________________ First: __________________________Middle: ______

Patient's Address: _______________________________City: ___________State: ___Zip:_____

Date of Birth: ______________________ Phone Numbers: ____________________________

Person or Facility To RELEASE Information:	Person or Facility To RECEIVE Information:
Name: _________________________________	Name: ______________________________
Address: _______________________________	Address: ____________________________
City: ______________State: ______Zip: ______	City: ______________State: ____Zip: _____
Phone: _______________Fax: _____________	Phone: _____________Fax: _____________

*I understand if I consent to the release of any medical records, the result of any HIV Antibody Testing is included in the medical records.__________ (INITIAL)

PURPOSE: ☐ Changing Physicians, ☐ Personal Copy, ☐ Attorney, ☐ Insurance, ☐ Other

This Authorization Will Expire On: _______________ (If no date specified, it will expire 60 days after date signed)

Signature of Patient/Legal Guardian: _________________________________ Date: ______________