MEDICAL RECORDS RELEASE

Patient Name: _____

Social Security Number: _____

Date of Birth:

_____

Release records from: Alabama Neurology Associates
509 Brookwood Blvd. Suite 101
Birmingham, AL 35209

Release records to:

Address: _____

City, State, Zip: _____

Phone/Fax: _____

Please specify records requested:

Reason for request: _____

I hereby authorize the named parties to release any information including the diagnosis and records of any treatment or examination rendered to me during my treatment.

Patient Signature

Date Received: _____ Date Completed: _____

Mail _____

Faxed _____

Pick-up_____