

NEURON MEDICAL CORPORATION

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SERVICES

General Neurology
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MEDICAL RECORDS AUTHORIZATION RELEASE

DATE: _____

TO: _____ Fax # _____

Ph. # _____

RE: PATIENT NAME: _____

DATE OF BIRTH: _____/_____/_____

I hereby authorize and request you to release the following medical records:

Patients Signature: _____

(Specify type of medical documents)

ALL Records: from _____ to _____ ALL: _____

H & P: from _____ to _____ ALL: _____

Labs: from _____ to _____ ALL: _____

MRI & MRA: from _____ to _____ ALL: _____

EEG: from _____ to _____ ALL: _____

Misc.: _____ from _____ to _____ ALL: _____

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Please fax records to: # 805-364-5464

or email to Neuronoffice@gmail.com