DOUGLAS NEUROLOGY ASSOCIATES, P.C.

Phone: 678) 838-2180 Fax: 678) 838-2193

Daniel Zdonczyk, MD **Preethi Natarajan, MD** **Jeffrey Charpentier, MD**

4586 Timber Ridge Dr, Suite180 Douglasville, Ga 30135

2615 East-west Connector, Suite122 Austell, Ga 30106

4374 Atlanta Hwy, Suite129 Hiram, Ga 30141

Authorization for Release of Medical Records

Patients Name: _____ Patients Phone #: _____

Date of Birth: _____ SSN: (last 4) _____

-Please Forward Copies of Requested Records

From:

Name: _____

Address: _____

_____

Fax: _____

To:

Name: _____

Address: _____

_____

Fax: _____

-Release The Following:

☐ Entire Medical Records

☐ Specific Dates of Treatment ___/___/____ To ___/___/____

☐ Other _____

I am requesting that this release of information be released for the following reason: ("at the request of an individual" is all that is required if you do not desire to state a specific purpose.)

_____

- This authorization shall remain in effect until _____ (insert date or "no expiration designated")
- I also authorize for the release of information regarding assessments, diagnosis, treatment, alcohol/drug abuse, and/or treatment of AIDS/HIV.

I understand i have the right to revoke this authorization, in writing, at any time by sending a written notification to Douglas Neurology associates, P.C., Attention medical release correspondent.

I hereby authorize Douglas Neurology associates, P.C. To disclose my medical information as requested. I understand that once this information is disclosed to a third party, that party may in return disclose to someone else who may not be a covered entity under HIPAA.

Patient Signature: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

PLEASE READ FEE INFORMATION

Douglas Neurology associates, P.C. copies and provides all medical record request from our office. We reserve the right to charge medical record state fee structure as set forth by the state statue. Copy charges plus postage may be invoiced to you from Douglas Neurology associates, P.C. with all of the necessary direction to receive your records. By signing this authorization, you are agreeing to pay Douglas Neurology associates, P.C. for your records.