Authorization to Release Medical Records & Information Form

Patient Name: _____ Date: _____ SS# _____
Address: _____ City: _____ State: ___ Zip: _____ Phone: _____

Number 1.

☐ I, _____ hereby authorize the following physician/clinic:

_____

to release medical records and information to **C**linical **N**eurology **S**pecialists.

Number 1 is for CNS to obtain your previous medical records from a specific medical facility or doctor.

Number 2.

☐ I, _____ hereby authorize **C**linical **N**eurology **S**pecialists to communicate my health care to the following family member/personal representative (PR):

a. _____
b. _____
c. _____
d. _____

Number 2 is authorization for CNS to speak to your family or PR about scheduling and your health condition.

Number 3.

☐ I, _____ hereby request my medical records and authorize **C**linical **N**eurology **S**pecialists to release my medical records to myself and/or family member or personal representative listed: _____

Number 3 is authorization for CNS to release your medical records to yourself and/or designated person. Please allow up to 30 days from the date of your request to have your medical records sent to your address listed above.

Do you give permission to **C**linical **N**eurology **S**pecialists to obtain and/or discuss your medical condition, examination or diagnosis with your primary care provider (PCP) and referring licensed health care provider (at times these may be two different providers):

Primary Physician	□ Yes □ No	Physician's Name: _____
Referring Provider	□ Yes □ No	Referring Provider: _____

Please list any family members you **DO NOT** wish CNS to discuss your health condition with:

a. _____
b. _____

Do you give **C**linical **N**eurology **S**pecialists permission to send this information electronically by fax or carrier?
□ YES □ NO _____Patient Initial

In the event we have to contact you and you are not home, may we leave a message on your machine/voicemail box or leave a message with your contact person/family member?
□ YES □ NO _____Patient Initial

Name of Contact Person: _____
Please note that unless revoked by patient in writing, this authorization release shall remain valid indefinitely.

_____

Patient Name (print) Patient Name (signature) Date

Las Vegas: * 1321 S. Rainbow Ste# 240 * Las Vegas, NV 89146 * Main# (702) 804-6555 * Fax# (702) 804-1273
Henderson: * 1691 W. Horizon Ridge Pkwy. Ste# 100 * Henderson, NV 89012 * Main# (702) 804-1212 * Fax# (702) 804-1273
Pahrump: * 1470 E. Calvada Blvd. Ste# 100 * Pahrump, NV 89048 * Main# (775) 537-6000 * Fax# (702) 804-1273