NEW YORK Epilepsy & Neurology PLLC

Consent for Medical Records Release

Name_____
Last First Middle

Home Address _____

_____

Telephone _____

Date of Birth _____

Dates of service to release _____ to _____

I hereby authorize New York Epilepsy and Neurology to release my medical records to:

_____
(name of hospital or other healthcare facility, physician, employer, union, or insurance carrier)

_____
(street address)

_____
(city, state, zip code)

_____

☐ **I will pick up my records**

There is no fee if the records are being released to a Physician. I understand that the Practice will charge me $0.75 per page, copying fee, if the records are going to the patient, or other parties on behalf of the patient.

_____ _____
Signature of Patient (or Personal Representative) Date

_____ _____
Printed name of Personal Representative Relationship

Mail to: NY Epilepsy & Neurology · Medical Records · 223 East 34th St. · New York, NY 10016
-or-
Fax to: 646-385-7170