ARIZONA NEUROLOGY ASSOCIATES
Providing comprehensive neurological care.

Andrew S. Gorman, DO
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MEDICAL RECORDS AUTHORIZATION

Patient Name_____ Date of Birth _____
Patient Address_____ Your Physician _____
Patient Phone_____

I authorize Arizona Neurology Associates to release or receive information:

_____ _____ _____
Name Telephone Fax

_____ _____ _____ _____
Address City State ZIP

Mailed ____ Pick Up _____ Faxed ____

Please release the following information from my medical records:

Complete Records ____ Hospital Records ____ X-Ray or MRI ____
Itemized Billing ____ Date of Service _____

The undersigned hereby authorizes the physicians to provide the above named person with a copy of any and all records, documents, reports, clinical abstract, histories and charts, of every kind and description relating to treatment of the patient described above except as indicated below.

This authorization shall be considered invalid after one year from the date of the signing. I may revoke this authorization at any time by providing the physician written notice of revocation. However, I may not revoke the authorization retroactively for information already released.

In furtherance of this authorization I hereby waive all provisions of the law and privilege relating to the disclosures hereby authorized.

_____ _____ _____
Patient Signature Relationship to Patient Date
Parent/Legal Authorized Representative

The purpose of the request (please check ALL that may apply):

Further Medical Care____ Insurance____ Disability____ Self____ Other:_____

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