Mir Neurology
NeuroSpine Center

REQUEST OF RELEASE OF MEDICAL RECORDS

Date: _____

Patient Information: _____

Date of Birth: _____

Social Security: _____

Contact # _____

REQUEST RELEASE OF INFORMATION FORM

Physician / Practice name: _____

Address: _____

_____

City: _____ State: _____ ZIP: _____

Contact #: _____ Fax #: _____

Please include the following items:

☐ Admission notes ☐ Operative Notes ☐ EKG ☐ X-rays ☐ Discharge notes

☐ Progress notes ☐ Labs ☐ EMG ☐ Consults ☐ Other

_____

Patient's Signature