Medical Release Form

☐ **MUTUAL PATIENT** ☐ **STAT** ☐ **URGENT/ASAP**

Date: ____ /____ /____

To: _____ ( ) -

Physician / Office Name Fax Number

RECORDS THAT WE ARE REQUESTING:

- ◯ All Medical Records _____
- ◯ Discharge Summary _____
- ◯ Echocardiogram/Holter/Stress Test _____
- ◯ Emergency Room Records _____
- ◯ Labs/Labwork _____
- ◯ Misc. Testing _____
- ◯ Office Notes _____
- ◯ X-Ray / CT / MRI / Ultrasound _____
- ◯ Sleep Study _____

I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization except as provided by law. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Thereby, I release **Universal Neurological Care** from all liability from this disclosure of my health information.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTOOD AND AGREED TO THE ABOVE TERMS AND CONDITIONS.

I hereby authorize the release of personal health information that may contain HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or copies of such, and request that they be transferred to:

Syed Asad, MD

Universal Neurological Care

8823 San Jose Blvd. Suite 209 Jacksonville, FL 32217

📞 : (904)-404-7044 | **Fax: (904)-329-2303**

_____

Print Name of Patient Date of Birth

_____

Signature of Patient

The contents of this document, together with any other documents, are intended only for the use of the person(s) to which they are addressed and may contain confidential and/or privileged information. Further, any medical information herein is confidential and protected by law. It is unlawful for unauthorized persons to use, review, copy, disclose, or disseminate confidential medical information.