



DOUGLAS NEUROLOGY ASSOCIATES, PC

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Authorization for Release of Medical Records

Patient Name: _____

Patient Phone #: _____

Date of Birth: _____

SSN:(Last 4 digits) _____

–Please Forward copies of requested records

From:

To:

Name: _____

Address: _____

City, State, Zip: _____

Fax #: _____

–Release the Following:

Entire Medical Record

Specific Dates of Treatment: From ___/___/___ To ___/___/___

Other _____

I am requesting that this protected information be released for the following reason: (“at the request of the individual” is all that is required if you do not desire to state a specific purpose.)

- This authorization shall remain in effect until _____ (insert applicable date or event or insert “no expiration designated”)
- I also authorize for the release of information regarding assessment, diagnosis and treatment of alcohol and/or substance abuse or mental/behavioral health status.
- I also authorize for the release of information regarding diagnosis and/or treatment of AIDS or HIV.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Douglas Neurology Associates, P.C., attention Medical Release Correspondent, at the above address.

I hereby authorize Douglas Neurology Associates, P.C. to disclose my medical information as requested. I understand that once this information is disclosed to a third party, that party may in return disclose it to someone else who may not be a covered entity under HIPAA.

Patient Name: _____

Patient Signature: _____

Date: _____

****PLEASE READ Fee information:** Douglas Neurology Associates, P.C. copies and provides all medical records requested from our office. We reserve the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage may be invoiced to you from Douglas Neurology Associates, P.C. with all the necessary directions to receive your records. By signing this authorization, you are agreeing to pay Douglas Neurology Associates, P.C. for you records.**

CLINICAL POLYSOMNOGRAPHY
COMPUTERIZED AXIAL TOMOGRAPHY
MAGNETIC RESONANCE IMAGING

ELECTROENCEPHALOGRAPHY
EVOKED POTENTIALS
ELECTROMYOGRAPHY