NEUROLOGICAL SERVICES, P.C.
463 Worcester Road
Framingham, MA 01701

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Your medical records cannot be released until this form is completed and signed by the patient or legal guardian.

Step 1	**Information about you:** Patient: _____ Last First M.I. Date of Birth: _____ (mm/dd/yyyy) Address: _____ Street City/Town State Zip
Step 2	**Who has the records now?** I hereby authorize: _____ _____ _____ _____
Step 3	**Which records do you wish to release, and to whom?** To release the following information: ALL RECORDS Other (please specify): _____ To: _____ _____ _____
Step 4	Please sign below to authorize the release of your records to the recipient specified in Step 3. This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for further disclosure beyond recipient is required. _____ Signature of Patient _____ Signature of Parent/Guardian _____ Signature of Witness _____ Date
Step 5	**Release of Sensitive Information** I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis B testing/treatment, and/or sensitive information, I agree to its release. _____ Signature of Patient _____ Date
Step 6	In addition to the above signature, if you want your HIV (AIDS) testing/treatment records released you must sign below; I agree to the release of this information. _____ Signature of Patient _____ Date