



BURLINGTON NEUROLOGY & SLEEP CLINIC, PLC.

RELEASE OF MEDICAL RECORDS FROM BURLINGTON NEUROLOGY & SLEEP CLINIC P.L.C.

Please release any and all medical records related to me EXCEPT substance abuse (drug or alcohol), mental health and AIDS-related information, unless specifically authorized to be released below to:

Fax: _____

From: **Burlington Neurology & Sleep Clinic P.L.C.**
1225 South Gear Ave, Suite 153, West Burlington, IA 52655
Fax: 319-754-4412

I specifically authorize the release of confidential information related to: (Place a "yes" or "no" to ALL of the following:)

ALCOHOL ABUSE _____ DRUG ABUSE _____
HIV/AIDS RELATED _____ MENTAL HEALTH _____
SEXUALLY TRANSMITTED DISEASES _____

Purpose of Disclosure (please check all that apply):

Changing physicians _____ Consultation/second opinion _____ School _____
Continuity of care _____ Insurance _____ Worker Compensation _____
Legal _____ Attorney Name, address & Phone _____
Other (please specify): _____

I understand that this release is voluntary and I may cancel this consent to release information at any time by sending written notice. I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulation, or is not an individual or entity who has signed an agreement with such a person or entity, that the information described above may be redisclosed and will no longer be protected by the regulations. This release expires one year from the date below unless otherwise specified.

SIGNATURE _____ **DATE** _____

NAME (please print) _____

BIRTHDATE _____ **PHONE NUMBER** _____

ADDRESS _____

(medical records release form 2/12)