



BURLINGTON NEUROLOGY & SLEEP CLINIC, PLC.

TREATMENT OF:

Neurology
Dementia
Epilepsy
Headaches
Multiple Sclerosis
Parkinson's Disease
Sleep Disorders

**RELEASE OF MEDICAL RECORDS TO 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:

Anil Dhuna, M.D., F.A.A.S.M
Board Certified in
Neurology, Sleep Medicine,
Neurorehabilitation and
Clinical Neurophysiology

Gautam Arora, M.D.
Board Certified in
Neurology and Board Eligible in
Interventional Pain Management

PROCEDURES

PERFORMED:

EMG & NCV
EEG & Video EEG
Botox Injection
Interventional Pain
Procedures
Independent Medical
Exams
Sleep Studies
Vagal Nerve
Stimulator (VNS)

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

Luanne Johnson, C-FNP
Certified Nurse Practitioner

Katie Reuter, C-NP
Certified Nurse Practitioner

From: _____

Fax: _____

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)