

RECORDS RELEASE

**FILL OUT THIS FORM TO ALLOW US TO SEND OUT YOUR RECORDS**

This form must be filled out in its entirety before we can comply with record requests. New York State law requires all patients requesting the release of their medical records to give permission in writing.

By completing this form, I authorize the release of my medical records from Neurology Consultants of New York, P.C.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Are you transferring your care out of our office?  YES  NO

If you only require specific reports or results, please specify which ones below:

Please release the records to:

Myself

Dr. \_\_\_\_\_

Other third party: \_\_\_\_\_

I would like my records to be:

Picked up in person at the office

Mailed to the following address: \_\_\_\_\_

\_\_\_\_\_

Faxed to ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

ATTN: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

RECORDS RELEASE

**FILL OUT THIS FORM TO ARRANGE FOR US TO RECEIVE YOUR RECORDS**

New York State law requires all patients requesting the release of their medical records to give permission in writing.

I, \_\_\_\_\_, authorize the release of my complete medical record, including progress notes, to Neurology Consultants of New York, P.C.

Please release my records to

Dr. Harold Weinberg  
Neurology Consultants of New York, PC  
650 First Avenue  
New York, NY 10016

FAX: 212.213.8459

Signature \_\_\_\_\_

Date: \_\_\_\_\_