MICHIGAN NEUROSCIENCE CLINIC

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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORD

Patient Name: _____ Date of Birth: _____

Provider Name: _____

Practice or Hospital Name: _____

City, Sate, Zip: _____

Phone: _____Fax:_____

I _____, authorize Michigan Neuroscience Clinic to obtain/release copies of the following medical records during my office visits and /or hospital admissions.

( ) Most recent office encounter

( ) Imaging studies (CT Head, MRI Brain, MRI Spine, CT Anglo, Carotid Doppler, 2d Echo)

( )Neurodiagnostic studies (EEG, EMG, VNG, VER, SEP, BAER)

( ) Other: _____

Release medical records to:
Michigan Neuroscience Clinic
Fax: 734-374-1119

_____ ____/_____/_____
Signature of Patient/Parent or Legally Authorized Representative **Date**

_____
Printed Name of Patient/Parent or Legally Authorized Representative
Relationship to patient: ☐**Spouse** ☐**Parent** ☐**Next of Kin** ☐**Legal Guardian** ☐**DPOA**

Thank you for your immediate attention to this request.