CENTER FOR COMPLEX NEUROLOGY EDS & POTS
MEDICAL RECORDS RELEASE FORM

PATIENT INFORMATION:

PATIENT NAME:_____

STREET ADDRESS: _____

CITY:_____ State _____ Zip _____

DATE OF BIRTH _____/_____/_____ PHONE (_____) _____

AUTHORIZES

PROVIDER NAME: _____
PROVIDER ADDRESS: _____
PROVIDER FAX: _____ PROVIDER PHONE: _____

TO DISCLOSE TO

David Saperstein, MD, Center for Complex Neurology, EDS & POTS

1010 E McDowell Rd., Suite 101, Phoenix, AZ 85006 Fax: (602) 903-6587

DATE(S) OF INFORMATION TO BE DISCLOSED/OBTAINED: From _____ to _____

□All medical records related to (specify condition, treatment, etc.): _____
□Radiology films/images (specify test): _____
□Specific records/information as follows: _____
_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED/OBTAINED (as defined by applicable state and federal laws): □Alcohol/Drug Abuse □HIV Test Results □ Mental Health / Developmental Disabilities

□**EXPIRATION:** This Authorization is good until the following date / event_____ □ Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.
□Other: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I also am aware that I may revoke this Authorization by notifying the Center for Complex Neurology, EDS & POTS in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

SIGNATURE OF PATIENT / LEGAL REP: _____ DATE: _____

If signed by a person other than the patient, complete the following:

1. Individual is: □a minor □legally incompetent or incapacitated
2. Legal authority: □parent* □legal guardian □next of kin / executor of deceased □activated POA for Health Care *
3. By signing above, I hereby declare that I have not been denied physical placement of this child.