

COASTAL NEUROLOGY, P.A.

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Port Royal, SC 29902
843/522-1420 ~ Fax 843/522-1460

To: _____

MEDICAL RECORDS REQUEST

I hereby authorize the release of my medical records to be faxed or forwarded to Coastal Neurology. Please FAX / MAIL the following information:

___ Entire Record
___ Problem List
___ X-Ray, CT, MRI etc.
___ Office Notes
___ Other: _____

___ Medication List
___ Discharge Summary
___ Laboratory Data
___ Hospital Records

Patient _____ DoB _____

SSN _____ Relationship _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____