**Coastal Neurology, P.A.**
**1833 North Paris Avenue**
**Port Royal, SC 29935-2029**
**843.522.1420 ~ Fax 843.522.1460**

# MEDICAL RECORDS RELEASE

**I, _____, hereby authorize the release of my medical records. Please fax / mail the following:**

**_____ Entire Record** **_____ Medication List**

**_____ Problem List** **_____ Discharge Summary**

**_____ Xray, MRI, CT, etc.** **_____ Laboratory Data**

**_____ Office Note(s)** **_____ Hospital Records**

**_____ Other:_____**

**For Personal Use _____** ***(There may be a reasonable fee for records processing)***

**or SendTo: _____**

**_____**

**_____**

**Phone#: _____**

**Fax #: _____**

**Patient Name_____ DOB_____**

**SSN_____ Relationship_____**

**Signature_____ Date_____**
***Patient / Legal Representative***

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***To Be Completed By Coastal Neurology***

**Records sent _____ by fax / mail. _____**
***Date*** ***circle one*** ***Employee Name***