COASTAL NEUROLOGY, P.A.

1833 North Paris Avenue
Port Royal, SC 29902
843/522-1420 ~ Fax 843/522-1460

To: _____

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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_____