ROCK CREEK
NEUROSURGERY

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: [DOB]

Patients Address: Phone Number:

Records will be sent to:

We do not send records by email. Your records can be sent by US Mail, Faxes, or picked up in our office.

This request and authorization applies to:

____ All Medical Records ____ Labs

____ Radiology/ Imaging ____ Operative notes

○ Yes ○ No I authorize the release of any records regarding mental health treatment to the person(s) listed above.

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.