Tallahassee Neurological Clinic, P.A.
1401 Centerville Road Suite 300
Tallahassee, Florida 32308
Main Phone 850-877-5115
Main Fax 850-656-3645

HIPAA Authorization to Use and Disclose Health Information

Medical Records Phone 850-558-1289
Medical Records Fax 850-558-1282

Patient's Last Name_____ Patient's First Name _____

Patient's DOB_____ Patient's SSN _____

Please Check All That Apply:

☐Complete copy of all records, as allowed by law.

☐Office Notes

☐Surgery Report

☐MRI/X Ray Reports

☐Lab Reports

☐Other Specific Section of Records (please specify)
_____

☐ Mental Illness or Developmental Disability

☐ HIV/AIDS testing or treatment

☐Child Abuse and Neglect

☐Sustance Abuse

☐Sexual Assault

☐Sexually Transmitted Diseases (STD's)

Authorization Valid For:

☐This request only.

☐One year from the date of this authorization OR ____/____/_____(insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐This request and for medical records of any future treatment of the type described above until:____/____/____ (insert date).

Please mail the records listed above to:

_____

_____ Or Fax To: (____)_____

_____

Signature of Patient or Patient's Representative:_____

Relationship to Patient: _____

Date:_____