Authorization For Release of Medical Records

Patient Name_____ Date of Birth_____

Address _____

City _____ State_____ Zip _____

Phone _____ Email _____

Release records from: **NeurExpand**

To whom should records be sent?

Requestor Name _____

Address _____

City _____ State_____ Zip _____

Phone _____ Email _____ Fax _____

I understand this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when Clary Document Management receives my notice in writing.

I hereby authorize you to transfer, or make available, copies of my medical records and reports to above named requestor. I understand I will be charged a $25 fee to reproduce the records and reports.

Patient Signature_____ Date _____

or

Patient Authorized Representative_____

please mail completed form and $25 check to address below:

Clary Document Management
4730 Quebec Avenue North
Minneapolis, MN 55428
ph (612) 588-8554
fax (763) 548-1325
chartcontrol@clarydm.com