MEDICAL RECORDS RELEASE

Patient Name:	
Date of Birth:	
Release records from:	Alabama Neurology Associates 509 Brookwood Blvd. Suite 101 Birmingham, AL 35209
Release records to:	
Address:	
City, State, Zip:	
Phone/Fax:	
Please specify records rec	nested:
Reason for request:	
	ed parties to release any information including the diagnosis nt or examination rendered to me during my treatment.
Patient Signature	
Date Received:	Date Completed:
Mail	
Faxed	
Pick-up	