KCA NEUROLOGY

get better...

Better Neurologists. Better Care. Better Results.

Phone: 615.550.1800 | Fax: 615.550.1819

PATIENT IDENTIFICATION

Name: _____

Date of Birth (DOB): _____ SSN (Last Four Digits): _____

Maiden/Aliases: _____ Cell: _____

RELEASE RECORDS TO:

KCA Neurology, PLLC
4323 Carothers Parkway
Williamson Tower Ste 609 | Franklin, TN 37067
Phone: 615.550.1800 | Fax: 615.550.1819

PROVIDER/FACILITY RELEASING INFORMATION

Provider: _____ Office: _____

Address: _____ City: _____ State: _____

Phone: _____ Fax: _____

INFORMATION TO BE SENT:

- ☐ **History & Physical Consultation Report**
- ☐ **Imaging/Labs/Pathology**
- ☐ **Progress Notes**
- ☐ **Procedure Notes/Reports**
- ☐ **Discharge Summary**
- ☐ **Other:** _____

PURPOSE OF RELEASE:

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that this authorization may be revoked in the writing at any time, except to the extent that action has been taken in the reliance of this organization.

I understand that the information released may be subject to the re-disclosure by some recipients and may no longer be protected by federal and state privacy rules related to health information.

This authorization expires: _____ *(If blank then 3 mos/90 days after date of signature)*

To revoke this authorization, please send a written request to KCA Neurology PLLC, at the address listed above.

Signature: _____

Name/Relationship (if other than patient): _____

SUBMIT