

KCA NEUROLOGY

FRANKLIN | HERMITAGE | CLARKSVILLE

Patient Identification

Name : _____

DOB : _____

Last 4 digits of SSN : _____

Maiden/Aliases: _____

Phone #: _____

Release Records To The Following:

KCA Neurology
4323 Carothers Parkway, Suite 609
Franklin, TN 37067
Phone: 615.550.1800 | Fax: 615.550.1819

Provider/Facility Releasing Information

Party Releasing Information: _____

Address: _____

Phone: _____

Fax: _____

Information To Be Sent

- First and Last Encounter Most Recent Imaging Most Recent Labs
 Other

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. Authorization expires 12 months from the date of signature

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

Signature of Patient/delegate: _____

Name of delegate (if applicable): _____

Date: _____