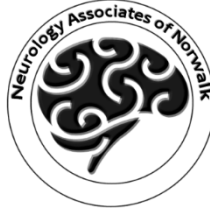


# NEUROLOGY ASSOCIATES OF NORWALK

605 West Avenue, Second Floor  
Norwalk, CT 06850  
(203) 853-5000 phone  
(203) 853-5001 fax  
NorwalkNeurology.com



Louis J. Cuzzone, MD  
Irina Taraban, MD  
Daryl R. Story, MD  
James L. Thompson, Jr., MD

## Medical Records Request

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

### I HEREBY AUTHORIZE NEUROLOGY ASSOCIATES AND RELATED ENTITIES TO:

release information to:  obtain information from:

NAME \_\_\_\_\_ COMPANY/PRACTICE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

### INFORMATION TO BE RELEASED OR OBTAINED (*CHOOSE ONLY ONE OPTION*):

- copy of items listed with dates of service: \_\_\_\_\_
- copy of most recent visits, testing & original consult
- copy of all medical records for the past \_\_\_\_\_ years
- copy of all medical records

1. I understand this authorization will expire one year after I've signed the form or as specified.
2. I understand that I may revoke this authorization in writing at any time, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
3. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand I am not required to sign this form in order to receive treatment.
5. **I understand that there is fee for copies of medical records which is \$0.65 per page plus postage.**  
As a courtesy, there is no charge if you are requesting only your most recent visits, testing & original consult to be faxed directly to another treating physician. By signing this request I agree to pay this fee prior to receiving my records.  
**Please do not request your records if you are not willing to pay the fee involved.**
6. I understand that information to be released or obtained may include mental health, substance abuse or HIV/AIDS related information.
7. I understand that a minimum of 3 days and maximum of 30 days are required for all requests.

SIGNATURE OF PATIENT OR AUTHORIZED PERSON \_\_\_\_\_ DATE \_\_\_\_\_

*IF SIGNED BY AN AUTHORIZED PERSON, A COPY OF LEGAL POWER OF ATTORNEY MUST ACCOMPANY THIS REQUEST*