NORTHSTAR NEUROLOGY
of Colorado Springs

Premier Medical Plaza
3920 N Union Blvd., Suite 150
Colorado Springs, CO 80907
Ph: 719-694-3595 | Fax: 719-493-9936

I hereby authorize Northstar Neurology of Colorado Springs, P.C. to transfer, release, or obtain information on:

_____ _____ _____
Patient Name Date of Birth Last 4 digits of SS#

OBTAIN FROM:	**DISCLOSE TO:**
_____ Physician/Institution	_____ Physician/Institution
_____ Address	_____ Address
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone Fax	_____ Phone Fax

Date(s) of Treatment: ☐ Specific dates: _____ thru _____ ☐ All Dates

Please check specific information requested:

☐ **All Records**	☐ Laboratory Reports	☐ Progress Notes
☐ Discharge Summary	☐ X-ray Reports	☐ MRI
☐ History & Physical	☐ Pathology	☐ CT Scans
☐ Medication Records	☐ Operative Report	☐ EEG/EMG Report

☐ Other (specify): _____

I understand that my records may contain but are not limited to: history diagnosis and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment, or genetic counseling. I give specific authorization for these records to be released. I understand that I may revoke this authorization at any time by sending a written notice. I understand that once my information is used or disclosed to this authorization, it may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient(s). I agree to hold, both sending and receiving parties to this request, harmless from any and all cost, liability, and danger of any nature resulting from the release of my medical record.

Authorization is valid for 6 months from the date of signature unless revoked in writing. I have read and understand this consent and I have signed it voluntarily.

_____ _____
Signature of Patient or Parent/Legal Representative Date

_____
Relationship to Patient (if not the Patient)

_____ _____
Witness Date