

Medical Records Release

To Whom It May Concern:

I authorize the release of my medical records from Four Peaks Neurology, P.C. to:

Fax to Fax Number: _____

Name: _____

Mail to Address:

Patients Name: _____

Date of Birth Month: _____ Day _____ Year _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____