ATHENS NEUROLOGICAL ASSOCIATES

REQUEST TO INSPECT AND COPY MEDICAL RECORDS

Patient Name:		Social Security Number:	
Date of Birth:		Phone Number:	
Street Address:		City, State, Zip Code:	

**To comply with HIPAA regulations we ask that you specify the release of Neuropsychological material.*

Please specify which records you would like copied:

- ☐ All Records (*including* Neuropsychological Records)
- ☐ All Records (*excluding* Neuropsychological Records)
- ☐ MRI images on CD
- ☐ All Records between the dates of ___/___/_____ and ___/___/_____
- ☐ Records pertaining to _____

Please specify the method of release:

- ☐ Pick Up
- ☐ Fax to: _____

☐ USPS Mail to:

_____

_____

_____

***Patient/ Guardian Signature: _____**Date:_____

Internal Use only: Completed By: _____Date: _____Fees for Copying/ Mail: _____