



**Authorization to Release Health Information**

Patient Name	Date of Birth
Telephone	Social Security

Other Names Patient has used \_\_\_\_\_

Send Records To:

Capital Region Neurosurgery, PLLC  
 1220 New Scotland Rd, Ste 103  
 Slingerlands, NY 12159

I  do  do not (check applicable box) authorize this information to be faxed.  
 If yes, fax number: 518-439-6143

This information is being disclosed for the purpose of Continuing Health Care.

For Healthcare Covering the Period(s)  all or from: \_\_\_\_\_ to \_\_\_\_\_.

Complete Health Record to be disclosed or (check appropriate boxes):

- Operative Report & Pathology Report
- History & Physical Exam     Progress Notes     Discharge summary
- X-rays/Ultrasounds         Laboratory Tests     Consultations

I understand that specific information to be release may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health.

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may a fee for preparing and furnishing thus information.

Signature of Patient or Legal Representative	Relation to Patient	Date
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