Charlotte Neurological Services, PLLC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I authorize release of any records or information regarding health treatment of the patient named above to:

Name: Charlotte Neurological Services, PLLC

Address: 6115 Park South Dr. • Suite 105

City: Charlotte State: NC Zip: 28202

Phone: 704.981.6800 Fax: 704.944.8389

I also authorize Charlotte Neurological Services to release any records or information regarding health treatment of the patient named above to members of the current treatment team (physicians, therapists, psychologists).

Patient Signature (if over 18yo): _____ Date Signed: _____

Parent/Guardian Signature: _____ Date Signed: _____