Emerald Coast Center for Neurological Disorders

Authorization for Release of Medical Records

Date of Request _____

Where _____

☐ By my signing below, I hereby authorize the release of my Medical Records, including all tests ordered, their results and examination notes from all providers to be released to:

Emerald Coast Center for Neurological Disorders
9400 University Parkway, Suite 109
Pensacola, FL 32514
Phone: 850-438-1136 or Fax: 850-438-1148

☐ By my signing below, I hereby authorize the release of my Medical Records, including all tests ordered, their results and examination notes from all providers to be released to the following:

_____
_____
_____
_____

_____ _____
Patient Name (print) *Date of Birth*

_____ _____
Signature of Patient or Guardian *Date*

_____ _____
Signature of Employee *Date*