HIPAA AUTHORIZATION TO RELEASE PATIENT MEDICAL RECORDS TO MAGNIFICNT MINDS NEUROLOGY CENTER

_____ _____
Patient's Full Name Patient's Date of Birth

_____ _____
Address Telephone Number

_____ _____
City, State, Zip Code Any other names used

I hereby request that my protected health information (PHI) be disclosed as directed below:
Facility to release records:

_____ _____ _____
Facility/Provider Name Office Location (City, State) Phone Number

_____ _____ _____
Facility/Provider Name Office Location (City, State) Phone Number

_____ _____ _____
Facility/Provider Name Office Location (City, State) Phone Number

_____ _____ _____
Facility/Provider Name Office Location (City, State) Phone Number

Records to be released to:

Magnificent Minds Neurology Center / Sonal G. Patel, M.D., 4416 East West Hwy, Suite 201, Bethesda, MD 20814
Phone: (301) 652-6800 Fax: **(301) 913-2817**

Please release the following records:

□ Any and all dates
□ Records from _____ to the present
□ Records from _____ to _____

□ Entire Medical Record
□ Clinic Notes
□ Radiology/Diagnostic Reports
□ Laboratory Reports
□ Surgical Reports
□ Emergency Department Record

_____ _____
Patient – or – Parent/Guardian Signature (if under 18) Date

_____
Patient – or – Parent/Guardian Printed Name, Relation to Patient

*This HIPAA release is valid for one calendar year unless revoked by signor or other legal parent/guardian. This HIPAA release must be updated and signed once minor patient turns 18 years of age.

*****IF YOU ARE SCHEDULED FOR A CONSULTATION AND HAVE RECORDS FROM ANOTHER FACILITY THAT WE NEED FOR THE APPOINTMENT, PLEASE EMAIL THIS FORM TO danielle.romano@priviamedicalgroup.com AT LEAST 3 DAYS PRIOR TO YOUR APPOINTMENT.**