RAAM SAMBANDAM, MD
BOARD CERTIFIED NEUROLOGIST

SYNAPSE
NEUROLOGY

AUTHORIZATION to RELEASE MEDICAL INFORMATION

I hereby authorize,_____, to disclose the following
Information regarding the continued case of.

Patient Name
_____DOB_____

Address
_____City_____State_____Zip_____

Phone (___)_____ Social Security # _____/____/_____

For the purpose of _____ Date of visit _____

Information to be released:

(_) Pertinent information (Doctor Report, Lab, Tests, X-Ray/MRI/CT)

(_) Copy of complete Medical Records

(_) Other

(_) Pick Up: _____
If other than patient person to whom the record to be released

(_) Mail: _____

This authorization will remain in effect until: _____

I further authorize Dr.Raam Sambandam to release any medical information including information related to psychiatric care, drug and alcohol abuse confidential information, acquired in course of my treatment necessary to process insurance claims or any medical information that is required for any health care utilization review or quality assurance activities. A photocopy of this authorization is to be considered as valid as original, until revoked by me in writing.

Signed:_____Date_____
Patient or representative

_____Date_____
Relationship to patient

Notice to recipient of information

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to the Federal Law, Federal regulations prohibit you from making any further disclosure of the information without specific written authorization of the person to whom it pertains, or is otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

Synapse Neurology
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