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BEHAVIORAL NEUROLOGY
CHILD AND ADOLESCENT NEUROLOGY

DIPLOMATE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
WITH SPECIAL QUALIFICATION IN CHILD NEUROLOGY
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REQUEST FOR ACCESS TO MEDICAL RECORDS

Name of Patient

I hereby request and authorize Dr. Eric Saslow to release medical information pertaining to the above named to:

Name of provider/person to whom information is to be released

Street Address

City, State, Zip Code

Telephone

for the purpose of: _____

TYPE OF ACCESS REQUESTED

Copies to be sent Copies to be picked up Discussion

SCOPE OF ACCESS REQUESTED

Medical record copies include office visit notes. Any further information must be specified. This authorization shall terminate six months from the date signed, if I do not revoke it earlier.

CHARGES

Copies: I understand that I will be charged twenty-five cents (\$0.25) per page, plus any additional reasonable clerical costs. I understand that these copies will be processed within two weeks of receipt of this request (rush requests require an additional fee)

Signature of Patient/Parent/Guardian/Conservator

Date

Printed Name

Relationship to patient

Telephone