MID ATLANTIC NEUROLOGY AND SLEEP MEDICINE, PA

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MEDICAL RECORDS RELEASE FORM

I, _____ hereby request my records to be released to me personally. I understand that it may take up to one week to prepare my records, as Mid Atlantic Neurology & Sleep Medicine must retain a copy for at least 10 years.

I, _____ grant permission for _____, to pick up my medical records in my absence.

Patient Signature: _____

Date of Birth: _____

Today's Date: _____

Phone Number: _____

Fax Number: _____

Mailing Address: _____

CHECK ONE: **OFFICE PICKUP** ☐ **FAX** ☐ **MAIL** ☐