



Associates In
Neurosurgery

Phillip G. St. Louis, M.D., FACS

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____

Social Security Number: _____ Date of birth: _____

Name of legal guardian or parent of minor: _____

I do hereby request that my medical records to be released to:

Associates in Neurosurgery
532 Virginia Drive
Orlando, FL 32803
Phone: (407) 898-8644
Fax: (407) 898-8646

I hereby request that the following records be sent:

- | | | |
|---|---|--|
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Consultation Records | <input type="checkbox"/> Lab/Pathology Reports |
| <input type="checkbox"/> EMG/NCT Reports | <input type="checkbox"/> Work Release Forms | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> X-Ray/Test Results | <input type="checkbox"/> All medical records | <input type="checkbox"/> Other _____ |

Patient or Legal Guardian/Parent Signature

Date

CONFIDENTIALITY NOTE

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