COMPREHENSIVE
NEUROLOGY
OF THE PALM BEACHES

Patient Request for Release of Protected Health Information

By signing this document, I authorize:

**Provide Name, Phone & Fax:**

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To disclose my protected health information to the doctor listed below. I am specifically requesting MRI's, MRA's, CT Scans, Labs, Neurology consult notes, EEG, and any medical records that may pertain to the patient's condition be sent to:

**Comprehensive Neurology of the Palm Beaches**
**Jennifer Buczyner, MD**
3502 Kyoto Gardens Drive Suite A
Palm Beach Gardens, FL 33410
**Or faxed to 561-246-3338**

I understand that this information will become part of my medical record and may be released as part of that medical record.

Patient's Printed Name:_____Date:_____

Patient's/Guardian Signature:_____

Patient's Date of Birth:_____SS#:_____

Guardian's Printed Name:_____Relationship:_____