



Neurology Specialists

A Division of
**Neurology
Consultants of
Tidewater, PLLC**

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Neurology
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Electromyography
Evoked Potentials
Epilepsy Monitoring
Sleep Disorder
Neuropsychology

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Medical Record Release

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Release records from: _____

Address: _____

City, State, Zip: _____

Phone/Fax: _____

Release records to: **Neurology Specialists
6161 Kempsville Circle, Suite 315
Norfolk, Virginia 23502
757/461-5400 fax 757/461-3305**

Please specify records to be released:

Reason for request: _____

This authorization expires on _____

I understand that I may revoke this authorization at any time by notifying Neurology Consultants of Tidewater in writing. However, if I choose to do so, I understand that my revocation will not affect actions taken by Neurology Consultants of Tidewater before receiving my revocation.

I understand that if the person or entity that receives this information is not a health plan or health provider covered by federal privacy regulations, the released information maybe re-disclosed by recipient and may no longer be protected by federal or state law.

Patient Signature _____

Date _____

Received _____