NeuroTek Inc.
Neurological Office & Diagnostic Testing Center

1210 Kingsley Ave. Orange Park FL 32073
Email: Neurotekoffice@gmail.com
Website: Neurotekinc.com

RECORDS RELEASE AUTHORIZATION

To_____

_____
FAX NUMBER

_____
ADDRESS CITY STATE ZIP

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

The complete medical records and best results in your possession, concerning my illness and/or treatment from the first visit to the last visit. This authorization includes the release of records relating to any drug or alcohol treatment,

Last Four of SSN #:_____

Name:_____DOB:_____

Address:_____
City State Zip

Signature: _____ Date:_____
(if relation, state relationship)

Witness: _____ Date:_____