Garden State
NEUROLOGY & NEURO-ONCOLOGY, PC
NEUROLOGY | NEURO-ONCOLOGY | MOVEMENT DISORDERS | MULTIPLE SCLEROSIS | STROKE | EPILEPSY | HEADACHE | EEG | EMG

100 State Highway 36 East, Suite 1A
West Long Branch , NJ 07764
tel. 732.229.6200

www.gsneurology.com
fax 732-229-6201

9 Hospital Dr, Suite A7
Toms River, NJ 08755
tel. 732.341.0200

Please send a copy of this release with requested records.

PATIENT INFORMTION (Please print)			
Patent Name		Date of Birth	
Address	City	Zip	Phone

RELASE FROM: (Name of physician or facility releasing information)

I authorize release of my medical record from

Physician/ Facility			Fax number
Address	City	Zip	Phone

RELASE FROM: (Name of physician or facility releasing information)

Please send my medical record to:

Physician/ Facility				
GARDEN STATE NEUROLOGY AND NEURO-ONCOLOGY, PC.				
Address 100 State HWY 36 East, Suite 1A	City West Long Branch	Zip 07764	Phone 732-229-6200	Fax 732-229-6201

RELASE INFORMATION

Reason [ ] Change of insurance [ ] Transfer of care [ ]Personal File
[ ] Moving out of area [ ]Specialist consultation [ ]Legal

Please release the following (check all the apply)

RECENT H&P		LAST THREE VISITS	
LAB/PATHOLOGY REPORTS		X-RAY/CT/ MRA/ MRI REPORTS	
HOSPITAL REPORTS		OTHER:	

- Use of this information for any other than the stated purpose is prohibited.
- This information is foe the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the record released might contain information relating to psychiatric or psychological testing, physical abuse, and/or drug and alcohol abuse.

Signature of patient, parent, guardian, conservator, or patient representative (please circle)

X_____ **DATE:** _____

Note: This consent may be revoked by the signer at any time.