



DENT

NEUROLOGIC INSTITUTE

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Medical Record Request

I authorize the disclosure of my medical information as described below. I understand that there is a fee of \$0.75 per page for acquiring records not being sent directly to another physician. Requests are processed by a copy service and are mailed out 7-14 business days from receipt of this request. No records are to be picked up at Dent.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Party Providing Information

Party Receiving Information

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Reason for Release: _____

Specify information to be disclosed – including dates:

Dates of Treatment: _____

Please Check All That Apply

Entire Medical Record _____

Laboratory Report _____

Diagnostic Report _____

Office Visit Notes _____

Pathology Report _____

Phone Messages _____

Signature of Patient or Patient's Representative

Date

Relationship to Patient

Inter-Office Use Only

Provider Signature (if applicable) _____

Initials of Staff Member _____

An Academic Private Neurology Practice affiliated with the Kaleida Health System and Roswell Park Cancer Institute

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DIAGNOSTIC SERVICES

MRI/CT EGG
EMG Sleep Studies
Carotid Doppler PET
Neuropsychology SPECT
Botox TCD