The Neurology Center
Allen M. Lifton, M.D.
200 Capri Isles Blvd; Suite 7d; Venice, FL 34292
Phone 941-485-2220 Fax: 941-485-2150

Patient Name: _____

Home Address: _____

Phone number: _____

Date of Birth: _____

Provider requesting medical records:

The Neurology Center
Allen M. Lifton, M.D
200 Capri Isles Blvd; Suite 7d; Venice, FL 34292
PHONE: 941-485-2220
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I hereby authorize any healthcare professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearinghouse, and insurance company to release all of my medical records to the above-mentioned facility and that they are authorized to receive my entire medical record, including all treatment records and diagnostic records. I understand that this authorization will allow the above-mentioned provider organization and its affiliates to use or disclose my protected health information for medical care, billing, and ordering of diagnostics, labs, insurance needs, and any other need related to my healthcare. I understand that my medical records may contain sensitive information such as mental health, HIV, AIDS, substance use disorders, sexual abuse, and/or other related conditions. I understand that these records are classified as privileged and confidential and cannot be released without my consent or the consent of a legal guardian. I also understand that should I want limited records released, I may provide that request in writing to the facility above. I understand that this request is for a release of my entire medical records for the purposes mentioned above. The signature below, including digital signatures, is to be used as authorization to release the medical records in a timely manner to The Neurology Center, Allen M. Lifton, M.D.

Signature of patient: _____

Date: _____

Legal Guardian Authorized signature
if the patient is unable to sign:_____

Printed name of Legal Guardian: _____

Relationship to patient: _____

Date: _____

Please list your Medical Providers

Patient Name: _____ **Date of Birth:** _____
Patient's Address:_____
Patient's Cell Number: _____

Medical Provider's Name: _____
Specialty: _____ Date Range of Visits: _____
Address: _____
_____
Phone:_____ **Fax to Retrieve Medical Records:** _____

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Specialty: _____ Date Range of Visits: _____
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_____
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