NEUROLOGY
ADULT & PEDIATRIC EPILEPSY
GENERAL NEUROLOGY

Malone-Davis Neurology
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Date: ____________________

Patient Name: ____ DOB: ______________________________

Social Security number: __________________________________

I, ____, authorize Malone-Davis Neurology, PLLC to release my information to the following:

Entity: ____

Phone: _________________________________FAX: ____________________________

____ ______________________________

Patient Signature Today's Date

Malone-Davis Neurology is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.