McMonigle Neurology Associates

RECORD RELEASE AUTHORIZATION

Patient Name:_____ SSN:_____ DOB:_____

Patient Address:_____

I authorize and request the release of any medical records, including medical history, laboratory reports, ultrasounds, and any other material regarding medical consultations and treatment, including information relating to Alcohol and Drug Abuse, Mental Health treatment, except psychotherapy notes, and STD testing. I have received from:

_____at_____

According to federal and state laws, I do not need to provide an explanation, and the records must be released timely, with no delay. Please forward the records to:

Dr. Jennifer McMonigle

554 Larkfield Rd., Suite 10G

East Northport, NY 11731

Patient Signature:_____

Date:_____