NEUROLOGY CLINIC
VERITYMD
HOPE, HEAL, ADVANCE

Authorization for the Release and Disclosure of Protected Health Information – Incoming

Indicate the name of the physician, hospital, medical center, or lab that you are requesting records from:

Name of entity to receive information: VerityMD Inc/Neurology Clinic
Address (number, street, city, state, zip): 5841 Jameson Court, Suite 2, Carmichael, CA 95608

Phone: (916) 500-4989 **Fax:** (916) 500-4990

I am requesting the medical information for the patient listed to be transferred to: (preferably via fax)

VerityMD Inc/Neurology Clinic
Attn: Medical Records 5841 Jameson Court, Suite 2, Carmichael, CA 95608
Phone: (916) 500-4989
Fax: (916) 500-4990

Please release the following information:
☐Complete Medical Record ☐Other - please specify:
I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral and/or mental health services and treatment for alcohol and drug abuse.

_____

Signature of Patient or Legal Guardian Relationship to Patient
Name:_____ Date of Birth:_____
Date of Signature: