Associated Neurology Medical Group, Inc.

Randall R. Starkey, MD
D. Eric Collins, MD
P. Suzanne Maska, MD

Authorization to Release Medical Records

I hereby authorize **Associated Neurology Medial Group, Inc**. to release medical records and data pertaining to:

_____ _____
Patient Name **Date of Birth**

_____
Street Address, City, Zip Code

Please specify who we are releasing records to:

_____ _____
Name **Phone Number**

_____
Street Address, City, Zip Code

Please specify what records should be released:

All Records _____ Records Pertaining To_____

Please specify method of release (HIPAA does not allow emailing):

Pick up _____ Mail_____ Fax To_____

Patient/Guardian Signature _____ Date _____

365 HAWTHORNE AVENUE #203
OAKLAND, CA 94609

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SAN RAMON, CA 94583

Ph: 510-834-5778 Fax: 510-834-0463

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