Maryland Brain & Spine
Authorization For Copy of Medical Records

I am having neurosurgical consult on _____ and hereby authorize:

Practice/Physician Name and Address: _____

_____

_____

_____

To send copies of my protected health information to

To: Maryland Brain & Spine Fax#: 410-224-0209
2002 Medical Parkway, Suite 430
Annapolis, MD 21401
Attention: Dr. _____

Type of information to be disclosed:

- ❑ MRI Report from _____
- ❑ CT Report from _____
- ❑ X-ray Report from _____
- ❑ Myleogram Report from _____
- ❑ Office Visits from _____ thru _____
- ❑ Therapy Visits from _____ thru _____
- ❑ Surgical Operative Notes from _____ thru _____
- ❑ Hospital Visit from _____ thru _____

This authorization will expire 180 days from the date of signed below.

Patient Name: _____ Date of Birth:_____

Signature of Patient or Legal Representative: _____

Relationship to Patient: _____ Date: _____

Confidentiality Notice: This facsimile transmission and the accompanying documents may contain confidential information which is protected by the physician/patient privilege. This information is intended only for the use of the individual entity named above. If you are not the intended recipient, you are herby notified that any disclosure, copying or distribution of this transmission is strictly prohibited. If you received this transmission in error, please contact us immediately by phone.