NEUROSCIENCE SPECIALISTS

Stan Pelofsky, M.D., Robert L. Remondino, M.D., Eric S. Friedman, M.D.,
Michael R. Hahn, II, M.D., Robert E. Tibbs, Jr., M.D., Robert J. Wienecke, M.D.,
Benjamin T. White, M.D., Brian E. Snell, M.D., Fadi F. Nasr, M.D., J. Bridger Cox, M.D.
4120 W. Memorial Road, Suite 300 • Oklahoma City, OK 73120 • (405) 748-3300 • (800) 742-3136 • Fax (405) 749-1671
Email: nss@neurosurg.org • Website: www.neurosurg.org

MEDICAL RECORDS REQUEST

Name: ______________________________
(**Please print for accuracy**)

Date of Birth: ______________________________

Social Security No: ______________________________
(**Last 4 digits**)

Phone Number: ______________________________
(**In case we need to contact you about this request**)

Date last seen: ______________________________
(**If unknown, give approximate year**)

Physician: ______________________________

Records Requested: ______________________________
(**Example: all records, MRI report, MRI films, office notes**)

I am requesting that my medical records be sent to:

Name: ______________________________

Address: ______________________________
____
(**Please provide address or fax number for speed and accuracy of your request**)

Signature: ______________________________

Date: ______________________________

The information authorized by this release may include data about communicable or venereal diseases which may contain, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome or AIDS.

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