Advanced Neurology
OF COLORADO

2121 East Harmony Road, Suite 180
Fort Collins, CO 80525
Phone: 970-226-6111 / Fax: 970-226-6707

Authorization to Release Medical Information

I, _____, hereby authorize the Advanced Neurology of Colorado to release pertinent verbal information regarding my medical care to/from the following people:

Name	Date of Birth	Relation to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I may revoke my consent at any time by a written notice. In the absence of my formal written notice this consent is revoked automatically 12 months from the date of my initial signature.

Advance Neurology Methods of Patient Contact
I understand that Advance Neurology of Northern Colorado may contact me by telephone for reasons related to my medical care at Advance Neurology, including but not limited to confirming or rescheduling appointments, notifying me of examination or test results, or following up in a continued effort to assure patient satisfaction. I further understand that some of these calls may be recorded messages or calls from an independent contractor working with Advance Neurology to assist in these patient contacts.

I understand that Advance Neurology will attempt to call and speak with me at the numbers that I have provided to them. I further authorize Advance Neurology, its employees and staff, and independent contractors working on behalf of Advance Neurology to leave a message on:

☐Home phone ☐Cell phone ☐Work Phone ☐Other _____
(Phone number)

☐I do not give Advance Neurology, its staff, or any independent contractors working with Advance Neurology permission to leave any messages or discuss any information regarding my medical care with anyone other than me.

_____ _____
Patient or Legal Guardian Date

_____ _____
Witness Date

REVISED 02/2014