Advanced Neurology
OF COLORADO

2121 E. Harmony Road, Suite 180
Fort Collins, CO 80528
Phone: (970) 226-6111
Fax: (970) 226-6707

1551 Professional Lane, Suite 125
Longmont, CO 80501
Phone: (970) 805-0950
Fax: (970) 805-0955

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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

Name: _____
Phone: _____ Relationship: _____

Name: _____
Phone: _____ Relationship: _____

Name: _____
Phone: _____ Relationship: _____

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.

Advanced Neurology of Colorado Methods of Patient Contact
I understand that Advanced Neurology of Colorado may contact me by telephone for reason related to my medical care at Advanced Neurology of Colorado, 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 Advanced Neurology of Colorado to assist in these patient contacts.

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

Home Phone: _____ Cell Phone: _____

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

_____

Patient/Legal Guardian **Date**