CSNA
Comprehensive Neurosciences

Release of Information (Contact List)

Please list individuals that you authorize your health care information to be released to in coordinating your care or payment for care. Indicate what information may be shared with each individual.

Name	Phone Number	Relationship to Patient	All	Scheduling/Appointments	Medical
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐

[ ] Information is not to be released to anyone.

Message Preferences

Please call [ ] my home [ ] my work [ ] my cell number

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Printed Name:_____DOB:_____

Signature:_____Date:_____

This **Release of Information** will remain in effect until terminated in writing.

To revoke this authorization, please send a written request to:

Colorado Springs Neurological Associates

Medical Records

2312 N. Nevada Avenue, Suite 100

Colorado Springs, CO 80907

If you have any questions, please call CSNA 719-473-3272