



AUTHORIZATION TO RELEASE

251 Keisler Drive Suite 100
Cary, NC 27518

101 Dennis Drive
Sanford, NC 27330

295 Olmsted Boulevard
Mellon Bldg, Suite 12
Pinehurst, NC 28374

I request and authorize the release of my healthcare information

(Name of Patient)

(Birthdate)

(Street Address)

(City, State, Zip Code)

Authorize Record Release FROM:

Release of Records TO:

(Name of Physician)

Henry Tellez, MD, Giridhar Chintalapudi, MD, and Greg Clary, MD

(Name of Physicians)

(Name of Health Care Practice)

(Name of Practice)

Sandhills Neurologists

(Street Address)

(Street Address)

295 Olmsted Blvd, Ste 12

(City, State, Zip Code)

(City, State, Zip Code)

Pinehurst, NC 28374

Records to be Released:

- Consultation Report
- Office Notes
- Laboratory Report
- History and Physical

ALL THE ABOVE

Henry Tellez
MD

Board Certified in Neurology
Vascular Neurology
Neuromuscular Medicine
Neuroimaging (UNCS)

I understand this release may include any records regarding, STD, drug, alcohol, or mental health treatment to the person(s) listed above. I have read and understand this authorization and authorize the disclosure of the health information noted above.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Giridhar Chintalapudi
MD, FAASM

Board-Certified in Neurology
Vascular Neurology
Neuromuscular Medicine
Sleep Medicine

- I agree that a copy of this release or a fax of this release shall be as valid as this original.
- I understand that I may withdraw this authorization at any time by submitting such request in writing to Sandhills Neurologists.
- The request to revoke the authorization does not affect any health information disclosed prior to Sandhills Neurologists receiving the written request.
- I release Sandhills Neurologists and any and all employees from all liabilities, responsibilities, damages, losses and claims which might arise from the release of authorized information.

Greg L. Clary
MD

Board Certified in Psychiatry
Internal Medicine
dTMS

Please send copies of all requested information to
SANDHILLS NEUROLOGIST FAX # 888-688-5254

Patient/Guardian Signature: _____ Date: _____