**CENTRAL VALLEY NEUROLOGY**
Jeffrey R. Levin, M.D. FAAN
Board Certified - Adult & Pediatric Neurology
1541 Florida Ave, Ste #300
Modesto, CA 95350

**www.jeffreylevinmd.com**

**Main Office Hours:** MON - THURS 9AM - 630PM (PST)
**Main Phone :** (209) 521-0767
**Main Fax :** (209) 521-5204

**For Medical Records Requests:**
**Medical Records Fax:** (209) 653-0280

# *2026 AUTHORIZATION TO RELEASE MEDICAL RECORDS*

Patient Name: *(Last, First)* _____

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

List Any Previous Name(s): *(Last, First)* _____

I request and authorize **Central Valley Neurology / Jeffrey R. Levin, M.D.** to release healthcare information of the patient named above to:

Name of Recipient: _____

Address: _____

City: _____ State: _____ Zip: _____

***Please check ONE box that this request and authorization applies to:**

☐ Healthcare information relating to the following treatment, condition, or dates:
_____
_____

☐ All healthcare information.

☐ Other: _____

☐ YES ☐ NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ YES ☐ NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ *Print Name*

_____ *Patient Signature or Authorized Representative*

___ / ___ / ___ *Date Signed*

***AUTHORIZATION VALID FOR ONE YEAR FROM DATE OF SIGNATURE***