

**Nancy Neighbors M.D.
Family Practice**

**2089 Cecil Ashburn Dr.
STE 101
Huntsville, AL 35802**

**Phone: 256-882-6085
Fax: 256-883-6638**

Date: _____

I hereby authorize the release of my medical records from:

(Doctor/Hospital)

Phone: _____

Fax: _____

Please transfer: Complete Medical Records
 Only records from _____ to _____

**Transfer to: *Dr. Nancy Neighbors*
2089 Cecil Ashburn Drive STE 101
Huntsville, AL 35802
*Phone: (256) 882-6085 Fax: (256) 883-6638***

Patient Name: _____
(Please print)

Date of Birth: _____

Signature of Patient/Guardian: _____