ADULT NEUROLOGY CENTER

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Authorization for Release of Protected Health Information

This authorization must be signed by the patient. If the patient is under 18 years of age, legally incompetent, or is unable to sign, the parent or guardian must provide authorization.

Patient's Name____ Date of Birth __________________

Address____ SSN _______-________-________

City ____________________________________ State______ Zip ________ Phone # _______-_______-_______

I Hereby Authorize the Adult Neurology Center, P.C. to:* ☐ *Release To or* ☐ *Obtain From

Name ____

Address ____ City ______________________________

State _______ Zip _________ Fax # _________-_________-_________ Phone # _________-_________-_________

Information to Be Released/Obtained:

☐ Entire Record ☐ Medication List ☐ Most Recent H&P ☐ All Records from the Past Year ☐ Discharge Summary

☐ Lab Results from _____________________ to _____________________

☐ Imaging Results/Reports from _______________ to _______________: Type (MRI, X-ray…) _______________________

☐ Other ____

This information will be used for the following:

☐ Treatment, Payment, Operations

☐ Other ____

- I understand that the information in my health record may include information related to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I may revoke this authorization at any time by submitting a written notice of revocation. I understand that this notice cannot be revoked if the records have already been released.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I may refuse to sign this authorization. My refusal will not affect my treatment or payment for my care.
- In the case of a minor child: I certify that no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.
- I the case of a deceased patient: I, the undersigned next of kin, certify that I assumed responsibility for the disposition of the body of the deceased. There has been no probate of the decedent's estate and there is no intent to enter the estate into probate.

Unless otherwise revoked, this authorization will expire one year from the date shown below

____ ____________________________

Signature of Patient or Representative Date

____ ____________________________

Printed Name of Patient or Representative Relationship to Patient

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FOR OFFICE USE ONLY:

Request taken by: _________________________ Date: __________________

Records released by: _______________________ Date: __________________

Processing Fee: _________________________

Identification Verified By:

☐ Patient known to staff

☐ Photo ID obtained

☐ Signature checked