Associates in Neuroscience

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# MEDICAL RECORDS RELEASE OF INFORMATION

_____ _____ _____ - _____

Printed Patient Name | Date of Birth | Last 4 SSN (Optional)

I hereby freely and voluntarily authorize **Associates in Neuroscience** to release my private health information to:

Person/Institute Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

Street | City, State | Zip Code

The purpose of this disclosure is _____

By checking the spaces below, I specifically authorize the release or disclosure of the following records and/or information, if such records and/or information exists:

| | | |
|---|---|---|
| ____ Face Sheet | ____ Medication Records | ____ Radiology Report |
| ____ Discharge Summary | ____ Neuropsychological Testing Report | ____ EKG/EMG/EEG Report |
| ____ History & Physical | ____ Emergency Report | ____ Operative Report |
| ____ Progress Notes | ____ Laboratory Report | ____ Itemized Bill |
| ____ Nurse Notes | ____ Other _____ | |

Approximate dates of treatment: From _____ To _____

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above-named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

Patient Signature: _____ Date: _____

**** (Patients 12 years of age or older)**

Parent/Guardian Signature: _____ Date: _____

**** (If patient is less than 18 years of age)**

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REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Associates in Neuroscience, SC cannot guarantee that the Recipient receiving the health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.