NEUROAUSTIN

Authorization for Release of Protected Health Information

PATIENT

Patient Name_____ Date of Birth_____

Last four digit of your Social Security Number: ### - ## -_____

RELEASE RECORD TO

☒ Myself for Personal Use or _____

Name _____ Phone_____

Address_____ Fax _____

City, State, Zip _____

Confirm email (print clearly) _____

PLEASE RELEASE FOLLOWING

☐Discharge & Summary ☐Lab Report ☐Pathology Reports

☐Consultation Note ☐Diagnostic Reports ☐EKG, EEK, Sleep Study

☐OP Reports ☒All

PURPOSE OR NEED FOR DISCLOSURE

☐Attending Physician Statement ☐Consultation ☐Payment of Claim

☐Disability Determination ☐Legal Investigation ☐Further Medical Care

☐Personal ☐Other

I hereby authorize the release of my medical records, including all results and tests that may include the following data: Drug, alcohol, and psychiatric treatment to the party noted above.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke/revocation this authorization at any time except to the extent that action has been taken. This authorization will expire ninety (90) days from the date of my signature or as otherwise specified by date, event, or conditions as follows:

_____ _____

Signature of Patient **Date**

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