Child and Adolescent Neurology Consultants

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/INFORMATION

Patient's Name: _____ Date of Birth: _____

I authorize _____ to release healthcare information
{Name of Physician)

of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Via: Fax Number: _____

DURATION: This request and authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless otherwise specified.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. I understand I have the right to revoke this authorization in writing by mailing a copy of the revoking document to the physician's office above. My written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.

Re-DISCLOSURE: I understand that a potential exists for the protected healthcare information disclosed pursuant to this authorization to be subject to re-disclosure by the physician's office identified above or its representative, and that such re-disclosure is not protected by the provisions of HIPPA.

SPECIFY: Medical Information/ Dictations: _____ Tests: _____
(Please check all that apply)

Psychiatric Information: _____ Other: _____
(Specify Records/ Informatlon)

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Date: _____ Signature: _____

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL