ADULT NEUROLOGY CENTER

1025 Jefferson Avenue, Washington, PA 15301

Phone: 724-229-6195 **Fax: 724-229-6199**

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 _____

Specially protected information: The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released;

Substance abuse records(drug/alcohol) Yes ☐ No ☐ Initials ____

Mental health records protected by the Mental Health Procedures Act Yes ☐ No ☐ Initials ____

HIV/AIDS related information Yes ☐ No ☐ Initials ____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- You have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Adult Neurology Center. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date:_____. If I fail to specify a date, this authorization will expire 365 days from the date signed.
- Treatment may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____

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